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by

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Date June 18, 1980

ABSTRACT

The major purpose of this exploratory descriptive study was to determine the attitudes of occupational and physical therapists toward role autonomy.

The data were gathered from registered, active members of the Alberta Association of Registered Occupational Therapists (AAROT) and the Association of Chartered Physiotherapists of Alberta (ACPA).

The definition of autonomy used in the study was defined by Friedson (1970) who conducted a sociological study of the profession of medicine. He defined the concept of autonomy as the degree to which work could be carried on independently of organizational or medical supervision, and also the degree to which it could be sustained by attracting its own clientele independently of organizational referral or referral by other occupations, including physicians.

The major hypothesis for the study stated that occupational and physical therapists will indicate preference for role autonomy (i.e., in areas of practice, control and organization). Eleven additional hypotheses were developed to examine factors which tended to influence role autonomy.

Occupational therapists were found to indicate a higher degree of preference for role autonomy than the

physical therapists. Relationships between role autonomy and job satisfaction, job dissatisfaction, professional knowledge and service ideal were found to be generally weak, though some of the relationships were statistically significant.

Thus, support was found for the notion that occupational therapists now desired a higher degree of autonomy in their professional practices while the physical therapists have indicated by their responses that time was not ripe for such demand.

ACKNOWLEDGEMENTS

This study was made possible by the excellent cooperation of various people and organizations.

To Dr. James Balderson, the writer extends a special note of gratitude for his continual encouragement, advice and constructive criticism during various stages of the study.

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Finally, and most of all, the writer expresses his sincere thanks and appreciation to his wife, Yinka, his children, Ronke, Bayo and Kole, for their cooperation and sacrifice. To them I dedicate this thesis.

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PART I

INTRODUCTION

CHAPTER I

THEORETICAL FOUNDATION

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THEORETICAL FOUNDATION

The main purpose of this research study was to determine the attitudes of occupational and physical therapists toward role autonomy. Data were gathered from registered, active members of the Alberta Association of Registered Occupational Therapists (AAROT) and the Association of Chartered Physiotherapists of Alberta (ACPA).

The definition of autonomy used in this study was provided by Friedson (1970) who conducted a sociological study of the profession of medicine. He defined autonomy as:

> ...the degree to which work can be carried on independently of organizational or medical supervision, and the degree to which it can be sustained by attracting its own clientele independently of organizational referral or referral by other occupations, including physicians. (p. 53)

Friedson (1970) further pointed out that before a paramedical occupation could attain the autonomy of a profession, it must control a fairly discrete area of work that can be separated from the main body of medicine and that could be practiced without routine contact with or dependence on medicine.

From the above definition, one can infer that there is an unusually high degree of skill and knowledge involved in the work of a professional. Pavalko (1970) cited eight dimensions of this knowledge and skill that could be considered as crucial in differentiating professions from occupations (Pavalko, 1971: 26). These are:

1. A firm core of theory and intellectual technique;
2. Relevance to social values;
3. Long and specialized training period;
4. Motivation influenced by service;
5. Autonomy;
6. Long term commitment;
7. High sense of community; and
8. Highly developed code of ethics.

Pavalko was, however, careful to point out that these characteristics constitute a "heuristic device" and that work groups "in reality" possessed these characteristics in varying degrees.

Based on the foregoing, this study explored whether the Alberta registered members of the occupational and physical therapy associations agreed with the views expressed in the literature and research findings calling for autonomy and professionalism in their work. The following research objectives (RO) were therefore formulated.

RO_1 To determine the degree to which occupational therapists would prefer role autonomy.

RO_2 To determine the degree to which physical therapists would prefer role autonomy.

RO_3 To determine the degree to which both the occupational and physical therapists have similar opinions regarding role autonomy.

RO_4 To determine the nature of the relationship, if any, between the degree of orientation the occupational therapists have toward professionalism (i.e., service and knowledge) and their degree of orientation toward role autonomy.

RO_5 To determine the nature of the relationship, if any, between the degree of orientation the physical therapists have toward professionalism (i.e., service and knowledge) and their degree of orientation toward role autonomy.

RO_6 To determine the nature of relationship, if any, between the degree of orientation the occuptional therapists have toward role autonomy and their orientation toward job dissatisfaction.

RO_7 To determine the nature of relationship, if any, between the degree of orientation the physical therapists have toward role autonomy and their orientation toward job dissatisfaction.

RO_8 To determine the nature of relationship, if any, between the degree of orientation the occupational therapists have toward role autonomy and their orientation toward job satisfaction.

RO_9 To determine the nature of relationship, if any, between the degree of orientation the physical therapists have toward role autonomy and their orientation toward job satisfaction.

The Definition of Terms

Occupational Therapy: is an applied social science eclectically drawing upon the biological, social and behavioral disciplines for the basic understanding of man, occupation and social organizational systems. Within this framework, occupational therapy provides service/treatment to both children and adults.(Occupational therapy prospectus, University of Alberta).

Occupational Therapist: a person who has undergone a training program from a recognized occupational therapy school and graduated with at least either a diploma or a bachelor's degree in occupational therapy and is eligible to practice in Canada.

Physical Therapy/Physiotherapy: is an applied science which calls for the basic understanding of zoology, chemistry and other related science subjects in order to treat disorders such as fractures, sprains, nervous diseases and heart trouble as prescribed by a physician, using all the therapeutic arts.(The Encyclopedia of Careers and Vocational Guidance Vol II Careers and Occupations, 1975).

Physical Therapist/Physiotherapist: a person who has undergone a training program from a recognized physiotherapy or physical therapy school or college and graduated with at least either a diploma or a bachelor's degree in physical therapy and is eligible to practice in Canada.

Attitude(s): as used in this study is a predisposition of the individual to evaluate some symbol or object or aspect of his world in a favorable or unfavorable manner.... Attitudes include the affective, or feeling care of liking or disliking, and the cognitive, or belief elements which describe the effect of the attitude, its characteristics, and its relations to other objects (Dawes, 1972, p. 16).

Professionalism: is defined as a set of attitudes said to be characteristic of professionals. It is said to include such attitudes as commitment to one's work as a career so that one's work becomes part of one's identity and an emphasis on public service rather than private profit (Freidson, 1970, p. 70).

Professionalization: as used in this study refers to the sequence of steps by which a semi-profession, through its transactions with the society, is transformed into a recognized profession (Etzioni, 1969, p. 274).

Profession(s): Lieberman (1970) defines it as that chief distinguishing characteristic which is the application of an intellectual technique to the ordinary business of life, acquired as the result of prolonged and specialized training (p. 55).

Professional(s): according to Lieberman, professionals are endowed with a skill which is measured by the probability that a layman would fail at the assigned task with varying degrees of practice (p. 55).

Role Autonomy: as used in this study refers to those functions and duties of professional nature which occupational and physical therapists are expected to carry out independently of organizational and medical supervision. These functions and duties are related to the practice, control and organization of occupational and physical therapy professions.

RELATED LITERATURE

The purpose of this chapter is to present a review of the literature and research findings related to the purpose of this study. The review is divided into three parts: (1) review of literature and research findings in occupational therapy; (2) review of literature and research in physical therapy; and, (3) conclusion and possible implications of the study for occupational and physical therapy professions.

The paucity of literature and research findings in the Canadian journals of occupational and physical therapy encouraged the writer to augment the information contained in this chapter with the literature and research provided by the American Occupational Therapy Association and the American Physical Therapy Association journals.

Review of Literature and Research Findings in Occupational Therapy

Autonomy. According to Bridle (1979), from its early beginnings, under th aegis of medicine, occupational therapy has received a legacy of subordination and submission to external pressures and commands. It is therefore not surprising to find that among the numerous problems that presently beset occupational therapy, the first and most essential one is autonomy. The issue has engaged the concern of many occupational therapists in the last two decades (AOTA, 1969; Jarvis, 1979; Johnson, 1973, 1977; Tate, 1974).

Most prominent among these was the resolution of the American Occupational Therapy Association (AOTA) in 1969 when they recommended that the "service of qualified occupational therapists be provided to those in need of that service, directly without the requirement of a physician's referral" (p. 211). The association's argument was predicated on the belief that today's multidisciplinary case conference wherein various health professions pooled both the findings of their respective evaluations and their recommendations for programming had made unrealistic the concept that the physician was the only member Of the health team who suggested services from each discipline.

Yerxa (1967) noted the tremendous changes and development that were then apparent in the field of occupational therapy and said:

> The written prescription is no longer seen by many of us as necessary, holy or healthy.... The pseudo-security Of the prescription required that we pay a high price. That price was the reduction of our potential to help clients because we often stagnated at the level of applying technical skills. (p. 2)

It is, however, interesting to note that the above views were not supported by the findings of Lehmann's (1973) study designed to determine the attitudes of occupational therapists toward role autonomy. He found that although the majority of subjects agreed that occupational therapy should be more independent than it was at the time, most of them felt that complete independence from the physician's referral or prescription was not necessary. The study also noted that those therapists who had been practicing for more than ten years were generally accepting of this control and were not dissatisfied with the prescription formula.

According to some writers, certification and licensing were issues which existed to maintain control over access to any profession. Woodside (1977) found that there were statutory licensing bodies for occupational therapists in five provinces in Canada. In the other provinces, national non-statutory registration was bestowed on the basis of completion of a course in occupational therapy accredited by the Canadian Association of Occupational Therapists (CAOT) and the fulfilment of a four-month internship or the completion of a course of training approved by the World Federation of Occupational Therapists (W.F.O.T.).

In the United States, Brayley (1976) and Hillbrath (1976) felt that there was need for legal recognition of occupational therapists in order to protect the public's health, safety, and welfare. In a research survey conducted by the Florida State Association of Occupational Therapy to sound out the opinions of the members regarding licensure, Hillbrath reported that 98% of 400 occupational therapists and 35 assistants polled, indicated their support for licensure (p. 35).

Stating the key issues and problems to be faced as occupational therapists 'go licensure,' West (1976) cautioned that:

> Possession of a licensure does not guarantee or assure protection of patients. It will not do so because this is a moral obligation dependent upon the integrity of the professional, and professionalism cannot be legislated. Professional standards must and will always be higher and stronger than those set by law. (p. 43)

Professional Knowledge

One cannot underestimate the fact that the existence of a body of knowledge serves as the basis for legitimizing the actions of professionals. It is therefore not surprising that the development of the present level of professional knowledge in occupational therapy has engaged the attention of therapists over the years.

In 1973, the Committee on Graduate Education of the American Occupational Therapy Association noted that the profession was ready to focus on the organization, development and validation of its body of knowledge. The Committee therefore recommended that this could be achieved through the traditional functions of graduate education. Supporting this view, Fidler (1977) stated:

> To expect that the art and science of occupational therapy can be learned, that the attitudes, the cognitive, research, and judgement skills required of a professional can be developed within a four-or five-year post-high school education, strongly suggests that we misunderstand the breadth and depth of a profession and that we are indeed caught in the dilemma of saying one thing (we are a profession) and doing another (providing vocational education for our practitioners). (p. 655)

She therefore advised that only graduate level education could provide the profession with a unique body of knowledge.

Maxwell and Maxwell (1979) also noted that if occupational therapy was to avoid "mobility deprivation," graduate training should be encouraged.

Writing on the sixtieth anniversary of occupational therapy, some writers felt that occupational therapy was in crisis, characterized by confusion over its role and identity.

Kielhofner and Burke (1977) made some predictions about a paradigm that would emerge in future which would attempt to solve the two problems of "theoretical inadequacy of reductionism and the deterioration of the philosophical base in occupational therapy." The authors recommended that the profession should shift its attention to "General Systems Theory" which would understand man as a symbol using social organism.

From another perspective, Reilly (1969) advocated that occupational therapy should move away from the medical model in order to create its own knowledge base and an orientation to a way of thinking. She wrote:

> We have identified the critical difference between medicine and occupational therapy as: It is the task of medicine to prevent and reduce illness; while the task of occupational therapy is to prevent and reduce the incapacities resulting from illness. (p. 300)

The issue of specialization in occupational therapy as a way of applying new knowledge to the improvement of care was given credence by some writers. In a keynote address to an annual general meeting of the American Association of Occupational Therapists, Silver (1979) advised that there was a need for specialization in all the professions, arising from "the inexorable and necessary aspect of the growth of knowledge and social demand" and resulting in "the compulsion to continually relate specialism to the common good."

Gillette and Kielhofner (1979) drew some helpful perspectives on the evolution of specialization in occupational therapy. While Kielhofner saw specialization as possibly leading to fragmentation and precluding development of a stronger generic identity, Gillette viewed specialization as one aspect of the drive toward professionalization and the autonomy implicit in achievement of that goal.

Diasio (1979), resting her premise on perspectives from General Systems Theory, argued for the need of specialization in occupational therapy but cautioned that integration with the whole, namely a generic or core knowledge base, was essential. Fidler (1979) also supported this view.

Clark (1979) suggested that the direction of new graduates toward specialities was inevitable, but warned of "elitist" attitudes that resulted from specialization expertise.

Research Findings

Since the inception of master programs in occupational therapy, some researches were carried out to determine the need and adequacy of such programs.

Lucci (1974), in a questionnaire survey of programs, identified as the "basic master" and of graduates through June of 1972. She found that 80% of the respondents stated that their educational program prepared them to be competent therapists, 10% indicated it did not, 8% were ambivalent and 1% questioned the degree of competency.

Christiansen (1975) randomly selected recently graduated occupational therapists to determine their perceptions of the adequacy of their professional training. Based on the findings of the research, Christiansen concluded:

> ..., perhaps more consideration needs to be given to the alternatives of either extending the length of programs to allow more in depth courses, or allowing specialization at some point during the student's advanced training. Additional study on the questions of specialization and basic program length seems warranted. (p. 355)

Believing that occupational therapy education was inadequate to prepare the therapists for managerial positions, Gilewich (1979) conducted a survey research to gain a perspective of occupational therapists engaged in managerial positions across Canada. She found that:

> 53% of the respondents reported no specific course work (either in university undergraduate, graduate, continuing education or other form) prior to assuming a management position. 83% of these respondents have taken courses specific to management prior to or since assuming a management position. (p. 136)

In a well documented study of occupational therapy in Canada, Maxwell and Maxwell (1979) reported the findings of their study on graduate education of occupational therapists.

In the survey, the authors asked occupational therapists and those medical practitioners and administrators in health care field most closely associated with occupational therapy, the type of degree requirements they envisaged for entry into practice in various positions in occupational therapy between 1980-85.

The authors reported that a very small percentage of each group saw staff therapists as requiring more than a bachelor's degree. Some felt the old style three-year diploma was still adequate. A relatively high percentage of the therapists saw the bachelor's degree as adequate for both private practice (68%) and community team therapists (82%).

When the authors looked at the percentages of each group recommending master's or doctoral degrees for the broad range of positions in occupational therapy, the percentages of medical specialists and administrators recommending these graduate degrees was higher than the percentages occupational therapists themselves who thought graduate education was required.

They also found that 25% of the respondents experienced the need for someone with greater expertise in their departments either daily or at least twice a week.

Service Ideal or Collectivity Orientation

According to Maas, Specht and Jacox (1975), accountability should be required of professionals in order to discourage the misuse of autonomy in their own interest. They believed that functionally, autonomy and accountability could not be separated.

Writing on accountability programming for occupational therapists, Dunning (1975) stated:

> Since occupational therapists work in a variety of settings with different age groups and with both normal and disabled clients, each therapist must create an accountability plan appropriate to the setting and client group. (p. 38)

On challenges facing occupational therapy, Johnson (1977) said:

> Occupational therapists have always valued humanitarianism but the imposition of accountability today creates innumerable conflicts as one attempts to balance personal and professional values or ideals within the realities imposed by the system, culture, or society within which one works or lives. (p. 113)

Realizing the tremendous concern for ethics today, both in education and in the delivery of health services, Welles (1976) agreed that in reality if an association of providers adopted a uniform set of principles, it would enhance the stature of all of them far more than if each individual was held responsible only for his own. She advised that:

> ...occupational therapy as a discipline accepting concern for those it serves must establish a broad, inclusive code of ethics, together with accompanying guides and education, consultation, and problem-solving services to facilitate their implementation. (p. 44)

In the past, occupational therapists have apparently used strategies of diffidence and deference which they now perceive to be ineffective for professional development in an era of accountability and financial restraint. Political strategies have been recommended as appropriate and effective for achieving professional goals (Maxwell and Maxwell, 1977; O'Shea, 1979).

In the Queens University study of occupational therapy completed by the Maxwells in 1977, 78% of respondents were dissatisfied with the recognition of occupational therapy profession by society at large, 58% were dissatisfied with recognition by other professionals, and 90% of those surveyed thought that the public undervalued the profession.

Concerned with the lack of acquisition of professional identify, O'Shea (1977) provided research based on "interactional theory" which investigated students acquisition of professional identity during initial practicum experiences. She found that students' belief in their performance as occupational therapists was weakened by inattention to the "dramaturgical elements" of their performance.

This led to the students' difficulty in eleciting a sincere response from clients. She also found that students also lacked preparation in appropriate role behavior which resulted in advertent role confusion and presentation of an unconvincing performance. Based on these findings, she noted:

> ...absence of cognitive awareness of our interactional behavior not only potentially restricts our own effectiveness in promoting personal professional development but in addition perpetuates through education, behavior patterns which are maladaptive for professional change. (pp. 107-108)

Review of Literature and Research Findings in Physical Therapy

Autonomy. The general desire for more independence has been apparent in the physical therapy literature for some time and has usually called for increased independence in colleague relationships with physicians (Bartlett, 1979; Goetz, 1978; Magistro, 1976; Mathewson, 1974; OPA, 1979; Rosen, 1978; Semple, 1974).

In his presedential address, Magistro (1975) listed autonomy as one of the critical issues acting as road blocks to a rapid development of the profession. The Canadian Physiotherapy Association (1978) was no less vocal in its demand for autonomy when the Association unanimously resolved to remove compulsory referral from the Association's code of ethics at their annual general meeting.

Bartlett (1979), while offering some caution to those therapists who were demanding complete independence of practitioner referral, warned:

> No matter what services are to be provided, the key to better health maintenance and health care is interdependence among members of the health care team. (p. 1385)

Rosen (1978) who also showed some concern about the militant demand for autonomy warned that:

> We are in danger of trying to usurp the function of another profession, and in so doing we are downgrading our own.... We are not licensed to diagnose or prescribe.... Our profession should stop confusing "evaluation" with "diagnosis" and our schools of physical therapy should stop trying to make MDs of us. (p. 69)

Noteworthy, however, is that after a long and bitter struggle with the American Medical Association, the American Physical Therapy Association was granted the permission to institute its own accreditation programs in January 1977 (Bartlett, 1979; Magistro, 1975).

Research Findings

Prominent among research findings on the issue of autonomy in physical therapy was the Ontario Physiotherapy Association's 1979 research on medical referral. To buttress their claim that their educational preparation had provided them with extended scope of practice, the Association gave the following data from the research conducted in Ontario, 1978.

Of the 9,630 charts from 130 institutions in Ontario, only 12% of the referrals provided information on the medical, psychosocial history of the patient relevant to the care required. Seven percent gave advice on restrictions or contraindications and only 17% provided any information on the physician's treatment goal. With the scanty referral information provided, the therapists had to acquire pertinent information from the patient before commencing treatment.

It was interesting to note that 44% of the referrals surveyed requested that the therapist make the decisions regarding care. Armed with these findings, the Canadian Physiotherapy Association noted the consumer's growing dissatisfaction with accessibility to health care. The association reaffirmed their unequivocal support for the Pickering Report (1973) which noted:

> Without the need for physicians' referral, patients could consult a physiotherapist as needed, either for a first incident of dysfunction or with recurring symptoms for the same problem. Physiotherapy would be an alternate entry into recognized health services. (OPA, 1979, p. 42)

Another important research finding was provided by Seymour, Connelly and Gardner (1979) in their attitudinal survey of physical therapists toward continuing education for relicensure. They found that of the majority of respondents, 73% were in favor of mandatory continuing education for relicensure while 24% were against with only 3% no opinion. When the 73% of the respondents were then asked if they preferred periodic re-examination rather than mandatory continuing education for relicensure, 8% responded affirmatively and 92% said they were not in favor of periodic re-examination for relicensure.

Based on these findings, the investigators believed that the argument was based on the need for a profession to prove to the consumer its commitment to improve the quality of health care. "Mandatory continuing education is one such mechanism for proving this commitment" (p. 403).

Professional Knowledge

Since the establishment of the first school of physiotherapy at the University of Toronto, practice and knowledge have proliferated at a fast pace.

According to Semple (1974), the board of directors of the Canadian Physiotherapy Association passed a resolution to the effect that only graduates of university based programs would be approved for membership of the Association in the future.

Lubkowsk (1974), Pady (1974), and Valentine (1973) supported the resolution believing that it was only through professional education students could acquire the knowledge, skills and attitudes to prepare them for complete acceptance of the responsibilities, rights and priviliges of their profession.

Presently, within the profession, there is concern about the upgrading of the entry-level education to a post-bachelor's degree in physical therapy. As far back as 1970, Worthingham found in her study of basic physical therapy education that:

> If physical therapists are to assure a professional role in relationship to other health professions, including medicine, a closer approach to peer equivalence, mutual respect, and recognition of responsibility is essential. When the majority of practitioners are at the

> baccalaureate level, such an accomplishment is unlikely. (Bartlett, 1979, p. 1385)

However in 1979, the American Physical Therapy Association's (APTA) house of delegates resolved "that the American Physical Therapy Association adopt the policy that entry level education for the physical therapist be that which results in the award of a post baccalaureate degree" (p. 1397). The association further resolved that all educational programs for the physical therapist accredited by the APTA and all developing educational programs for the physical therapist which filed declarations of intent with the APTA and which subsequently became accredited by the APTA, should comply with the policy on entry level education in the resolution by December 31, 1990.

Supporting the resolution, Helewa (1979), in her presidential address to the Canadian Physiotherapy Association, noted:

> A master of science as a basic educational requirement for physiotherapists is not a novel idea; it was approved this year at the APTA's annual meeting. Such a degree has the potential of upgrading clinical skills and academic knowledge in our field. (p. 276)

Research has also been a major topic of discussion in educational settings and has had ample priority in the physical therapy activities.

Scott (1974) believed that accurate assessment and recording were the basis for research. She observed:

> It seems to be the most reasonable way to create a foundation which is essential for substantiation of physiotherapy methods. It allows treatment to be changed whenever necessary, providing the changes and reasons are recorded. It also requires the development of vigorous evaluative procedures. (p. 157)

After specifying areas in physical therapy where research could make great contributions, Basmajian (1977) said:

> Research is essential to a profession. It is a true well spring from which physical therapy will derive present and future sustenance, accelerated growth, and the ability to help millions of handicapped people. (p. 284)

He went further by offering an uncompromising recommendation when he stated that research was mandatory if physical therapy was to remain identified as a true profession rather than a respected technology.

Responding to the demands of various practitioners of physical therapy for the active development of research, Bartlett (1979) revealed in his presidential address the development of "Guidelines for Fostering Research in Physical Therapy" and "Plan to Foster Clinical Research on Physical Therapy." Inherent within this plan was the conviction that the profession of physical therapy must make greater efforts to acquire evidence to support its practice. The implications of the plan were far-reaching. Such a comprehensive approach to fostering clinical research would involve many segments of the Association and the profession.

Pleading for support from the Federal government, Helewa (1979) urged the government to establish an Allied Health Research Council similar to the Medical Research

Council. She observed that:

> As long as Medical Research Council in Ottawa is and continues to be "medical" in its orientation, physiotherapy and allied health professionals have a slim chance of competing successfully for funds. (p. 277)

Speculating on the future of physical therapy, Valentine (1973) noted that the art and science of the profession could not be developed within a four or five year post high school education. She added that:

> Most physiotherapists have come to accept the need for specialization if our profession is to continue to evolve and to maintain its standing as a valuable member of the health professions team. (p. 131)

Siding with the above views, the American Physical Therapy Association's House of Delegates adopted a resolution in 1975 calling for the establishment of a formal program for certification of advanced clinical competence by the APTA. Their reasons were grounded in the assumption that formal recognition of advanced clinical competence through the Association's certification of specialists and generalists could benefit both the physical therapists and the public by promoting high standards of practice, by rewarding excellence in clinical practice, and by facilitating referral of patients with special needs. Clinical specialization was also endorsed by Hislop (1975) and Bartlett (1978).

Service Ideal or Collectivity Orientation

At the tenth Mary McMillan lecture, Hislop (1975) devoted a substantial part of her lecture on the essence of professionalism in physical therapy. On the survival of the profession, she stated that it is:

> By providing a unique and distinct service to the people--service not equaled in its excellence, breadth, or comprehensiveness by any other group. (p. 1078)

In his presidential address, Magistro (1975) stated that one of the militating factors against professionalism in physical therapy was the Standards for Accreditation of Hospitals as they affected the practice of all hospital-based physical therapists. He was opposed to any standard which interposed a secondary physician between the referring practitioner and the physical therapy service.

Addressing also the issue of professionalism in physical therapy, Bartlett (1979) reasoned that:

> ...I judge that it is an accepted fact that physical therapy during the past five decades has moved to a higher level of professionalism yet careful evaluation of our current professional status reveals certain shortcomings that continue to inhibit its further growth and development. (p. 1327)

Bartlett listed these major deterrents as: (a) lack of an appropriate scientific body of knowledge specific to the profession; and, (b) lack of broad community sanction by the public with which physical therapy associated and the resulting approval by the public of their professional authority.

Expressing her dissatisfaction with the exclusion of allied health professionals in the formulation of moral policy decisions in health care, Purtilo (1978) argued that health professionals ought to be included in the policy-making process so that they would not cease to feel accountable. She added that:

> Physical therapists have traditionally been identified as care givers. In the minds of some therapists and many other persons, this tended to exclude them from policy-making roles at any level except perhaps within their professional organization. (p. 1076)

Research Findings

Barnes and Crutchfield (1977) examined job satisfaction-dissatisfaction factors among a sample of 25 physical therapists engaged in private practice and 25 physical therapists employed as chiefs of departments in a survey research. The purpose was to determine the meaningfulness of work for physical therapists and to compare private practitioners with therapists who worked with an organization. They found that 10 factors out of the 16 studied were significantly satisfying or dissatisfying for all therapists.

Organizational therapists were satisfied with the work itself and valued recognition for their efforts, whereas private practitioners were more concerned with personal responsibility. Organizational therapists experienced periods of unhappiness with some aspects of interpersonal relationships and with some policies of the organization, and private practitioners were unhappy with long working hours.

Theoretical Framework

Among the many characteristics that differentiate a profession from an occupation, the concept of autonomy, self-regulation and self-control which are synonyms for freedom to regulate its work behavior appears the most important (Eliot, 1970; Etzioni, 1969; Freidson, 1970; Lieberman, 1970; Katz, 1968; Vollmer and Mills, 1966).

This point of view was implicitly recognized by Illich, Zola, McKnight, Caplan and Shaiken (1977) when they noted that professional authority comprised three roles:

> ...the sapiental authority to advise, instruct and direct; the moral authority that makes its acceptance not just useful but obligatory; and charismatic authority that allows the professional to appeal to some supreme interest of his client that not only outranks conscience but sometimes even the raison d'etat. (pp. 17-18)

Lieberman (1970) also concurred with this view when he noted that because a professional could do a "specialized task" which by definition no one else could fully comprehend, he would demand autonomy in order to enforce and preserve his standards. But Clark in Vollmer and Mills (1966) emphasized that not all professional groups would need the same degree of autonomy. He stated:

> Professionals who largely give advice or follow the guidelines of a received body of knowledge required extensive but not great autonomy for the individual and the group. They need sufficient leeway to give an honest expert opinion or to apply the canons of judgement of their field. Those requiring great autonomy are those who wish to crawl along the frontiers of knowledge, with flashlight or floodlight in hand, searching for the new--the new scientific finding,

> the new re-interpretation of history, the new criticism in literature or art. (p. 286)

However valid may be the professionals' argument for autonomy and self-control, the views of other writers who have arguments against complete independence of the professional are also worthy of consideration. According to Lewis and Maude (1952), George Schwartz observed:

> It is regrettable that the public has to be on its guard whenever an occupation sets out to establish its status as that of a profession. For one thing, customers tend to be transformed into clients, which means that pounds are automatically converted into guineas. More serious is the fact that the occupation almost invariably lays claims to powers of self-regulation which insensibly or deliberately entail monopoly. (p. 31)

Professionalism and Professionalization

The most common approach used to arrive at a definition of professionalism has been inductive. It has consisted of an examination of the characteristics of those currently called "professionals." From this basic material a common denominator of essential criteria has been selected. The extent to which these criteria were met by different occupations indicated their position on a professionalization continuum. Pavalko (1971) has done a useful work in this area. He developed a conceptual model of occupation/profession continuum which consisted of eight dimensions of work which were considered as crucial in differentiating occupations from professions.

These eight dimensions could be collapsed into two main characteristics--knowledge and service--which Gross in Vollmer and Mills (1966) believed to be the most important criteria of an ideal-type profession. He stated:

> As any occupation approaches professional status, there occur important internal structural changes and changes in the relation of the practitioners to society at large. A useful way of discussing these changes is by reference to the criteria of professionalization: the unstandardized product, degree of personality involvement of the professional, wide knowledge of a specialized technique, sense of obligation {to one's art}, sense of group identity, and significance of the occupational service to society. (p. 9)

In describing a group of professions whose claim to the status of doctors and lawyers was neither fully established nor fully desired, Etzioni (1969) referred to these professions as semi-professions:

> Their training is shorter, their status is less legitimated, their right to privileged communication less established, there is less of a specialized body of knowledge, and they have less autonomy from supervision or societal control than "the" professions. (p. v)

Etzioni was, however, careful to point out that the term "semi-professions" was used without any derogatory implications.

Goode was also recorded to have said in Etzioni (1969) that many aspiring occupations and semi-professions would never become professions in the usual sense because they would never reach the levels of knowledge and dedication to service which the society would consider necessary for a profession. He gave examples of school teaching, nursing, librarianship, pharmacy, stockbroking and others as some of these professions.

Freidson (1970) was more emphatic when he stated:

> ..., those paramedical occupations which are ranged around the physician cannot fail to be subordinate in authority and responsibility and, so long as their work remains medical in character, cannot gain occupational autonomy no matter how intelligent and aggressive its leadership. To attain the autonomy of a profession, the paramedical occupation must control a fairly discrete area of work that can be separated from the main body of medicine and that can be practiced without routine contact with or dependence on medicine. Few if any of the present paramedical occupations deal with such potentially autonomous areas. (p. 69)

Perhaps part of the dependence of these paramedical occupations on medicine could be explained by what Pavalko (1971) referred to as "Professional Marginality." He described this phenomenon as "contradictions or inconsistencies in the extent to which work groups exhibit professional elements or characteristics that constitute the occupation-profession continuum" (p. 131). He cited occupational therapy as an example of a profession experiencing incomplete professionalization. Noting several factors in the historical development of occupational therapy that had prevented the emergence of a high degree of autonomy, he concluded that:

> The physician's prescription has remained, however, as a symbol of his control over treatment and is an apparently thorny reminder of the occupational therapist's subordinate status. (p. 36)

The issue of prevalence of women in most semi-professions was recognized as one reason for lack of autonomy and professional status for these professions.

Simpson and Simpson noted in Etzioni (1969) that:

> The predominantly female composition of the semi-professions strengthens...bureaucratic control in the organizations in which they work. The public is less willing to grant autonomy to women than to men. A woman's attachment is to the family role; women are therefore less intrinsically committed to work than men and less likely to maintain a high level of specialized knowledge. (p. 199)

Motivation-Hygiene Concept of Job Attitudes

According to Herzberg (1971), there were two sets of needs for a man--"his need as an animal to avoid pain and his need as a human to grow psychologically" (p. 71). The first set of needs he termed motivators which consisted of achievement, recognition, work itself, responsibility and advancement. The other--"dissatisfiers"--or hygiene factors which tend to produce short-term changes in job attitudes. The major dissatisfiers were company policy and administration, supervision, salary, interpersonal relations and working conditions. Herzberg further suggested that job factors which satisfy workers and job factors which dissatisfy workers are not arranged on a conceptual continuum but are mutually exclusive.

Related Research in Sociology

Sociological research in this area has been scanty and the existing ones have barely scratched the surface in assessing the extent to which large numbers of occupations and professions actually exhibit those criteria of professionalism. According to Pavalko (1971), present knowledge in this area was "impressionistic, dated, and frequently based on samples of questionnable representatives" (p. 27). Another problem he observed was that there was no logical or *a priori* way of determining what the relative weight of each of the dimensions of professionalism should be.

The two researchers mentioned below were concerned with comparative analysis of educational attainment of people in semi and established professions.

Reiss, reporting his study on occupational mobility of professional workers in Vollmer and Mills (1966), found that:

> Among professional statuses, the median years of school completed ranged from 16.4 years for men in established professions to 10.5 years for the marginal or semi-professions. Fourteen percent of marginal professionals graduated from college, while 90% of the established professionals graduated from college.

In another study done by Scott in Etzioni (1969), to determine that graduate training among social workers (one of those classified as semi-professions) would prompt them to choose professional reference groups external to their agency, Scott found that 39% of the 36 workers with some graduate training answered in the affirmative as compared to 22% of the 50 workers lacking graduate training.

Conclusion

In summary, the literature and research findings which have been cited in this chapter indicate the existence of the problem faced by emergent professions or professions in transition in their quest to change their position on one or more dimensions of the occupation-profession continuum.

First it was pointed out that the professionalization movement taking place in modern professions has been characterized by a drive toward autonomy. In essence, it is a thrust toward a better status, a greater independence and authority over decisions which have to do with professional matters. Such a thrust relies essentially on the possession of expert knowledge and its scope refers to the amount of authority acquired or granted to a professional, a group of professionals or a professional association over a range of decisions.

Secondly, the literature also identified the criteria of professionalism which were considered as germaine in differentiating professions from occupations.

Whether occupational and physical therapists can be considered professionals or where these professions stand on the professionalism continuum are still debatable matters, if not controversial issues. This study, therefore, attempted to find out whether the occupational and physical therapists agreed with the views expressed in the literature and research findings calling for autonomy and professionalism in their work.

CHAPTER II

RESEARCH HYPOTHESES

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RESEARCH HYPOTHESES

The hypotheses formulated in this chapter served as a guide in the exploration of the occupational and physical therapists' attitudes toward role autonomy. Factors which tend to influence the role autonomy were examined. The research hypotheses (RH) are presented below.

RH_1 There will be a preference for role autonomy (i.e., in areas of practice, control and organization) by registered occupational therapists in Alberta.

RH_2 There will be a preference for role autonomy (i.e., in areas of practice, control and organization) by registered physical therapists in Alberta.

RH_3 There will be no significant differences between the opinions of occupational therapists and physical therapists toward role autonomy.

RH_4 There will be a positive relationship between the orientation of occupational therapists toward role autonomy and their orientation toward professionalism (i.e., knowledge and service).

RH_5 There will be a positive relationship between the orientation of physical therapists toward role autonomy and their orientation toward professionalism (i.e., knowledge and service).

RH_6 Occupational therapists' orientation with respect to role autonomy will be positively related to their orientation toward job dissatisfaction.

RH_7 Physical therapists' orientation with respect to role autonomy will be positively related to their orientation toward job dissatisfaction.

RH_8 Occupational therapists' orientation with respect to role autonomy will be positively related to their orientation toward job satisfaction.

RH_9 Physical therapists' orientation with respect to role autonomy will be positively related to their orientation toward job satisfaction.

PART II

METHODOLOGY

CHAPTER III

INSTRUMENTS

CHAPTER III

INSTRUMENTS

This chapter describes and presents the instruments utilized in the measurement of variables previously discussed (see Appendix A). For this study, the instruments were selected from those employed by Lehmann (1973) and Maxwell and Maxwell (1977).

The items were grouped under two sections (B and C). Group B inquired the opinions of respondents about the general conditions of their work while Group C asked questions relating to concepts of autonomy, knowledge and ideal of service. Section A was conceived to obtain personal information.

General Information

The general information variables were designed by the writer to obtain pertinent information about each of the respondents. Five variables were deemed of importance to the current study. They were: (1) Sex; (2) Age; (3) Marital Status; (4) Present Work Position; and (5) Academic Qualifications.

Section A - General Information

Please place a check (✓) for the appropriate response.

1. Sex 1) _____ Male 2) _____ Female

2. Age

1) _____ 20 years or less
2) _____ 21 - 25 years
3) _____ 26 - 30 years
4) _____ 31 - 35 years
5) _____ 36 - 40 years
6) _____ 41 - 45 years
7) _____ 46 - 50 years
8) _____ 51 - 55 years
9) _____ 56 - 60 years
10) _____ 60 years and older

3. Marital Status

1) _____ Single
2) _____ Married
3) _____ Widowed, divorced or separated

4. Your Present Position (for occupational therapists only)

1) _____ Director
2) _____ Supervisor
3) _____ Sole Charge Therapist
4) _____ Staff Therapist
5) _____ Private Practitioner
6) _____ Private Consultant
7) _____ Government Consultant
8) _____ Other (specify)
____

Your Present Position (for physical therapists only)

1) _____ Director
2) _____ Asst. Director
3) _____ Senior Therapist
4) _____ Staff Therapist II
5) _____ Staff Therapist I
6) _____ Physiotherapist
7) _____ Owner Operator
8) _____ Other (Specify)
____

5. Your Academic Qualifications (for occupational therapists only)

1) _____ Diploma in Occ. Therapy
2) _____ Teaching Diploma in Occ. Therapy
3) ____ B.O.T. or B.Sc. (O.T.)

4) _____ Master's degree 5) _____ Doctoral degree
6) _____ Other (specify) ______________________________

Your academic qualifications (for physical therapists only)

1) _____ Diploma in Physiotherapy
2) _____ Teaching Diploma in Physiotherapy
3) _____ B.P.T. or B.Sc. (P.T.)
4) _____ Master's degree
5) _____ Doctoral degree
6) _____ Other (specify) ______________________________

Section B

This section contained 16 statements designed to measure the degree of satisfaction/dissatisfaction aspects of the work of occupational and physical therapists. The measure was accomplished by employing a rating scale of 1 to 6 from which respondents were required to check a number on the scale.

Very Dissatisfied 1 2 3 4 5 6 Very Satisfied

This section was developed from the instruments used by Maxwell and Maxwell (1977) in the Queen's University study of occupational therapy, and from those used by Herzberg (1971) in his study of two hundred engineers and accountants, who represented a cross-section of Pittsburgh industry.

Herzberg identified two levels of needs for his subjects: "hygienic" needs (which tend to focus on the dissatisfaction factors identified in his study) and satisfaction needs (which tend to focus on the satisfaction factors identified). According to Herzberg's hypothesis, some factors were satisfiers when present but not dissatisfiers when absent; other factors were dissatisfiers, but when eliminated as dissatisfiers did not result in positive motivation.

Job Satisfaction Questionnaire

Job dissatisfaction question contained five items from Section B which were conceived by the writer to measure job satisfaction of the respondents. The respondents were required to indicate the degree to which they were satisfied with each of the following items by checking a number on the scale.

Very Dissatisfied 1 2 3 4 5 6 Very Satisfied

Ques. No. 2. The opportunities for advancement in your position 1 2 3 4 5 6

3. The recognition you get from your job 1 2 3 4 5 6

7. The amount of decision-making by your position 1 2 3 4 5 6

8. The amount of responsibility demanded by your position 1 2 3 4 5 6

10. The feeling of accomplishment from the work you are doing 1 2 3 4 5 6

Job Dissatisfaction Questionnaire

This section contained eleven items taken from Section B which were meant by the writer to measure the dissatisfaction aspects of their work. The respondents were asked to indicate the degree to which they were satisfied with each of the following items by checking a number on the scale.

Very Dissatisfied 1 2 3 4 5 6 Very Satisfied

Ques. No. 1. The conditions under which you have to work (i.e., lighting, ventillation, space and equipment 1 2 3 4 5 6

4. The amount of pay you get for doing your job 1 2 3 4 5 6

5. The amount of job security you have in your position 1 2 3 4 5 6

6. Your control over the quality of your work 1 2 3 4 5 6

9. The extent to which you can use your skills 1 2 3 4 5 6

11. The opportunities to do the things you are really educated for, (as opposed to those things that people with less training can do just as well) 1 2 3 4 5 6

12. The extent to which the medical doctors accept you as a colleague within the health care system 1 2 3 4 5 6

13. The cooperativeness you receive from other health care personnel in your institution 1 2 3 4 5 6

14. The adequacy of your present professional qualifications 1 2 3 4 5 6

15. The confidence in your professional ability which your patients have in you 1 2 3 4 5 6

16. The extent to which you are left relatively free of supervision by others 1 2 3 4 5 6

Section C

This section contains 32 items which specifically measure professional role autonomy, and professionalism criteria, i.e. knowledge and service. The measure was accomplished by employing a rating scale of 1 to 6 from which respondents checked the most appropriate one, from Strongly Disagree 1 2 3 4 5 6 Strongly Agree.

These items have been developed from the instruments used by Lehmann (1973) for his doctoral thesis on occupational therapists' attitudes toward role autonomy and from those employed by Maxwell and Maxwell (1977) in their Queen's University study on occupational therapy.

According to Freidman (1970), self-regulative autonomy was the only truly important and uniform criterion for distinguishing professions from other occupational groups. He identified this as involving autonomy to practice, control and organize the professional activities.

Pavalko (1971) and Goode in Etzioni (1969) also identified the dimensions of professionalism as incorporating essentially intellectual knowledge and service ideal.

This section has therefore divided the items used into three categories, *vis* professional role autonomy, knowledge and service. Please note that the word occupational(s)/physiotherapist(s) has been used to denote the members of the two associations who responded to the questionnaire items. The contents of the questionnaire sent to the groups are the same (see Appendix A).

Professional Role Autonomy Questionnaire

This questionnaire contained 13 items from Section C deemed to measure the category. The respondents were to indicate the degree to which they agreed/disagreed with each of the following statements by checking a number on the scale.

Strongly Disagree 1 2 3 4 5 6 Strongly Agree

Ques. No. 1. Occupational therapists/physiotherapists should be permitted to terminate or continue the treatment of their patients as they deem fit 1 2 3 4 5 6

2. I feel more confident working with patients who have been referred to me by medical doctors 1 2 3 4 5 6

3. Occupational therapists/physiotherapists should be responsible for developing the budget for occupational therapy/physiotherapy departments in their facilities . 1 2 3 4 5 6

4. Occupational therapists/physiotherapists should be responsible for developing staff projections for the occupational therapy/physiotherapy departments in their facilities 1 2 3 4 5 6

5. Occupational therapists/physiotherapists should have final authority over their work 1 2 3 4 5 6

6. Occupational therapists/physiotherapists as members of health care team should be allowed to function more independently 1 2 3 4 5 6

7. Occupational therapists/physiotherapists within medical settings should be allowed to provide their services to clients in need of those services without the requirement of a physician's referral or prescription 1 2 3 4 5 6

Ques. No. 8. Occupational therapists/physiotherapists should be allowed to make their own decisions regarding problems that come up with the treatment of their patients 1 2 3 4 5 6

9. Many professions are provincially licensed with a licensure examination and, in some cases, occupational therapy/physiotherapy is licensed at the provincial level. To what extent do you agree that occupational therapists/physiotherapists should be licensed by examination in Alberta? 1 2 3 4 5 6

10. Membership in the provincial association should be a requirement to practice or hold a position 1 2 3 4 5 6

11. Membership in the national association should be a requirement to practice or hold a position .. 1 2 3 4 5 6

12. There should be a re-examination and relicensing for any occupational therapist/physiotherapist who wishes to re-enter practice after an absence of five years or more 1 2 3 4 5 6

24. Occupational therapists/physiotherapists should be evaluated only by their fellow occupational therapists/physiotherapists 1 2 3 4 5 6

Professional Knowledge Questionnaire

This questionnaire contained nine items purported to measure this category. The respondents were to indicate the degree to which they agreed/disagreed with each of the following statements by checking a number on the scale.

Strongly Disagree 1 2 3 4 5 6 Strongly Agree

Ques. No. 13. To what extent do you agree that occupational therapy/physiotherapy as a profession has a firm core of theory and knowledge like medicine? 1 2 3 4 5 6

14. I sometimes do things that I should have been better prepared for in my course in occupational therapy/physiotherapy 1 2 3 4 5 6

15. Continuing education in occupational therapy/physiotherapy should be developed to meet the future needs of the therapists . 1 2 3 4 5 6

16. Thinking of various jobs which occupational therapists/physiotherapists may hold five to ten years from now, Alberta would need a Master's program in occupational therapy/physiotherapy 1 2 3 4 5 6

17. To what extent do you agree that university education in occupational therapy/physiotherapy is adequate? 1 2 3 4 5 6

18. To what extent do you agree that occupational therapy/physiotherapy in a community college could be adequate to meet the training requirements of the profession? 1 2 3 4 5 6

20. I feel the need for someone with a higher level of expertise in occupational therapy/physiotherapy in my facility 1 2 3 4 5 6

23. To what extent did you agree that occupational therapy/physiotherapy training prepared you to conduct and report research? 1 2 3 4 5 6

26. My occupational therapy/physiotherapy education prepared me adequately to carry out administrative/supervisory duties 1 2 3 4 5 6

Service Ideal Questionnaire

Ten questionnaire items were conceived under this rubric by the writer to measure the category. The respondents were to indicate the degree to which they agreed/disagreed with each of the following statements by checking a number on the scale.

Strongly Disagree 1 2 3 4 5 6 Strongly Agree

Ques. No. 19. It should be permissible for an occupational therapist/physiotherapist to violate medical protocol if it is in the best interest of the patient 1 2 3 4 5 6

21. The best interests of occupational therapists/physiotherapists would be served by conforming to professional standards rather than to standards of their employing institutions 1 2 3 4 5 6

22. Occupational therapists/physiotherapists should be made more accountable for the treatment activities of their patients 1 2 3 4 5 6

25. Because of what I am able to do for society, I would like to continue in my present profession even if I could earn more money at another vocation 1 2 3 4 5 6

27. Occupational therapists/physiotherapists should be involved in determining the program which will best meet patient care objectives 1 2 3 4 5 6

29. Do you agree that occupational therapy/physiotherapy as a profession may be threatened by the growth and development of other occupations or professions? 1 2 3 4 5 6

For questions 29, 30 and 31, please respond in relation to this statement:

> In many professions there are problems such as lack of power and influence, difficulty in relation to other professions, etc. Thinking of occupational therapy/physiotherapy:

Strongly Disagree 1 2 3 4 5 6 Strongly Agree

Ques. No. 29. To what extent do you agree that the lack of a clearly defined area of competence in relation to other health professions account for some of the problems in occupational therapy/physiotherapy profession?........................... 1 2 3 4 5 6

30. To what extent do you agree that the lack of training of occupational therapists/physiotherapists in dealing with government and other professions account for some of the problems in the profession? 1 2 3 4 5 6

31. To what extent do you agree that the fact that the majority of people in the profession are women account for some of the problems in the profession? 1 2 3 4 5 6

Ques. No. 32. Listed below are ten occupations. Please rank them according to the way in which you think the public evaluates their social standing. Place the number "1" opposite the occupation to which you think the public attributes the highest social standing through to "10"--the occupation in the group to which you think the public attributes the lowest social standing.

___ Physicians

___ Dieticians

___ School Teachers

___ Laboratory Technologists

___ Registered Occupational therapists

___ Hospital Secretary

___ Prof. Social Workers

___ Physiotherapists

___ Registered Nurses

___ Radiographers

CHAPTER IV

RESEARCH SITE, DATA COLLECTION, COMPUTER FACILITIES

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RESEARCH SITE, DATA COLLECTION, COMPUTER FACILITIES

The selection of the research site, the collections of data, and the computer facilities used to process the data are described in the following sections.

Research Site

Encouraged by the findings of Lehmann's (1973) study of occupational therapists' attitudes toward role autonomy in the United States, the writer decided to explore the attitudes of Alberta registered occupational and physical therapists toward the same issue.

In order to procure the subjects to participate in the study, the writer first contacted the two associations' headquarters for the release of the current lists of their registered members. The Association of Chartered Physiotherapists of Alberta based in Edmonton refused the writer's request on the grounds, it was not in accord with the resolution of the Association's executives. The association, however, advised that a copy could be obtained from any of the registered members known to the writer. Subsequently, the writer contacted the Chairman of the Department of Physical Therapy, University of Alberta, who later released the list after an explanation on the purpose of the study. As for the Alberta Association of Registered Occupational Therapists, the list was released after receiving an explanatory letter from Dr. James Balderson, the writer's thesis advisor (see Appendix B).

Data Collection

From these two lists, the writer conducted a proprotionate random sampling of the two groups to be included in the study using a table of random numbers.

Toward the end of February 1980, the questionnaires were dispatched to those selected. Along with a guide for the administration and completion of the questionnaire, each questionnaire was accompanied by a letter indicating the purpose and the importance of the study.
Also included was a stamped, self-addressed envelope for the return of the completed questionnaire.

By mid March 1980, a follow-up letter was sent to remind all the subjects participating in the study of the importance of having a high percentage return (see Appendix C). All completed questionnaires were received through the office address of the Department of Educational Administration, University of Alberta. On April 7, 1980 (being the last day of expected returns), the writer compiled all the usable ones for data analysis. The criteria employed in deciding this is further explained in Chapter V.

In order to ensure a free and frank expression of opinions, the respondents were not required to sign their names. A space was also provided in the questionnaire to express any comments they wished.

Computer Facilities

The analysis of the data was performed by the utilization of programs and sub-programs contained in SPSS--Statistical Package for the Social Sciences (Nie *et al.*, 1975). Additional programs were written by Mrs. C. Prokop, Computer Applications Analyst, Department of Educational Administration, University of Alberta. The facilities of the Computing Sciences Department, University of Alberta, were employed for the processing of the data.

CHAPTER V

SUBJECTS

CHAPTER V

SUBJECTS

In order to be included in this study, subjects were required to be registered, active members of the Alberta Association of Registered Occupational Therapists and the Association of Chartered Physiotherapists of Alberta. From populations of 208 occupational therapists and 310 physical therapists, questionnaires were sent to 50% of each of these groups. The respondents were randomly selected.

From a total of 104 occupational therapists and 155 physical therapists, completed questionnaires were received from 69 occupational therapists and 71 physical therapists, representing 33% and 23% respectively of the population.

Questionnaires were considered acceptable for use only if the respondents indicated that they were presently working. A consequence of using this criterion resulted in the loss of seven respondents from occupational therapists and three from physical therapists. Consequently, respondents of 62 occupational therapists and 68 physical therapists, representing 30% and 22% respectively of the population, were used for the data analysis.

The following general description of the 62 occupational therapists and 68 physical therapists used in this study is based on data presented in Tables 5.1 and 5.2.

Table 5.1 presents personal data on occupational therapists. Ninety-seven percent of the therapists were female. Seventy-one percent were younger than thirty-six years of age, while twenty-nine percent were those with ages between thirty-six and fifty-five years of age. Sixty percent were married, thirty-two percent single and eight percent were either widowed, divorced or separated. Fifty-three percent were staff therapists while twenty-four percent were in senior positions (i.e., Directors and others). Sixty percent had a Bachelor's degree in occupational therapy while thirty-four percent constituted the Diploma holders.

Table 5.2 gives the relevant background information of the physical therapists. Ninety-one percent of the therapists were female. Seventy-two percent were younger than thirty-six while twenty-eight percent were older than thirty-six but less than fifty-six years of age. Seventy-three percent were married, twenty-two percent single, and three percent were either widowed, divorced or separated. Fifty-two percent represented basic grade and staff therapists while twenty-nine percent were in senior positions (i.e., Senior Therapists and Directors). Fifty-four percent had Diploma qualifications while forty-one percent had a Bachelor's degree in physical therapy.

Table 5.1

Background Items of Occupational Therapists
(N = 62)

Category	%
SEX:	
Male	--
Female	96.8
No Response	3.2
AGE:	
20 years or less	--
21 - 25 years	27.4
26 - 30 years	32.3
31 - 35 years	11.3
36 - 40 years	11.3
41 - 45 years	11.3
46 - 50 years	4.8
51 - 55 years	1.6
56 - 60 years	--
60 years and older	--
MARITAL STATUS:	
Single	32.3
Married	59.7
Widowed, divorced or separated	8.1
PRESENT POSITION:	
Director	8.1
Supervisor	9.7
Sole Charge Therapist	6.5
Staff Therapist	53.2
Private Practitioner	1.6
Private Consultant	1.6
Government Consultant	4.8
Other (Specify)	14.5
ACADEMIC QUALIFICATIONS:	
Diploma in Occupational Therapy	33.9
Teaching Diploma in Occupational Therapy	--
B.O.T. or B.Sc. (OT)	59.7
Masters degree	--
Doctoral degree	--
Other (Specify)	6.5

Table 5.2

Background Items of Physical Therapists
(N = 68)

Category	%
SEX:	
Male	7.4
Female	91.2
No Response	1.5
AGE:	
20 years or less	--
21 - 25 years	19.1
26 - 30 years	32.4
31 - 35 years	20.6
36 - 40 years	14.7
41 - 45 years	7.4
46 - 50 years	2.9
51 - 55 years	2.9
56 - 60 years	--
60 years and older	--
MARITAL STATUS:	
Single	22.1
Married	73.5
Widowed, divorced or separated	2.9
No Response	1.5
PRESENT POSITION:	
Director	14.7
Assistant Director	--
Senior Therapist	14.7
Staff Therapist II	19.1
Staff Therapist I	13.2
Physiotherapist	19.1
Owner Operator	8.8
Other (Specify)	10.3
ACADEMIC QUALIFICATIONS:	
Diploma in Physiotherapy	54.4
Teaching Diploma in Physiotherapy	--
B.P.T. or B.Sc. (PT)	41.2
Master's degree	--
Doctoral degree	--
Other (Specify)	4.4

CHAPTER VI

EMPIRICAL FINDINGS OF QUESTIONNAIRE ITEMS

CHAPTER VI

EMPIRICAL FINDINGS OF QUESTIONNAIRE ITEMS

Occupational and physical therapists' responses to the items of the Job Satisfaction Inventory, Job Dissatisfaction Inventory, Professional Role Autonomy, Professional Knowledge and Service Ideal Scales were each subjected to analysis by the SPSS subprogram FACTOR (PA 2), i.e. principal factoring with iteration.

This program "automatically replaces the main diagonal elements of the correlation matrix with communality estimates . . . employs an iteration procedure for improving the estimates of communality" (Nie *et al.*, 1975: 480).

Factor analysis was utilized in order to determine the degree to which a given variable or several variables are part of a common underlying phenomenon or characteristic (Nie *et al.*, 1975: 10).

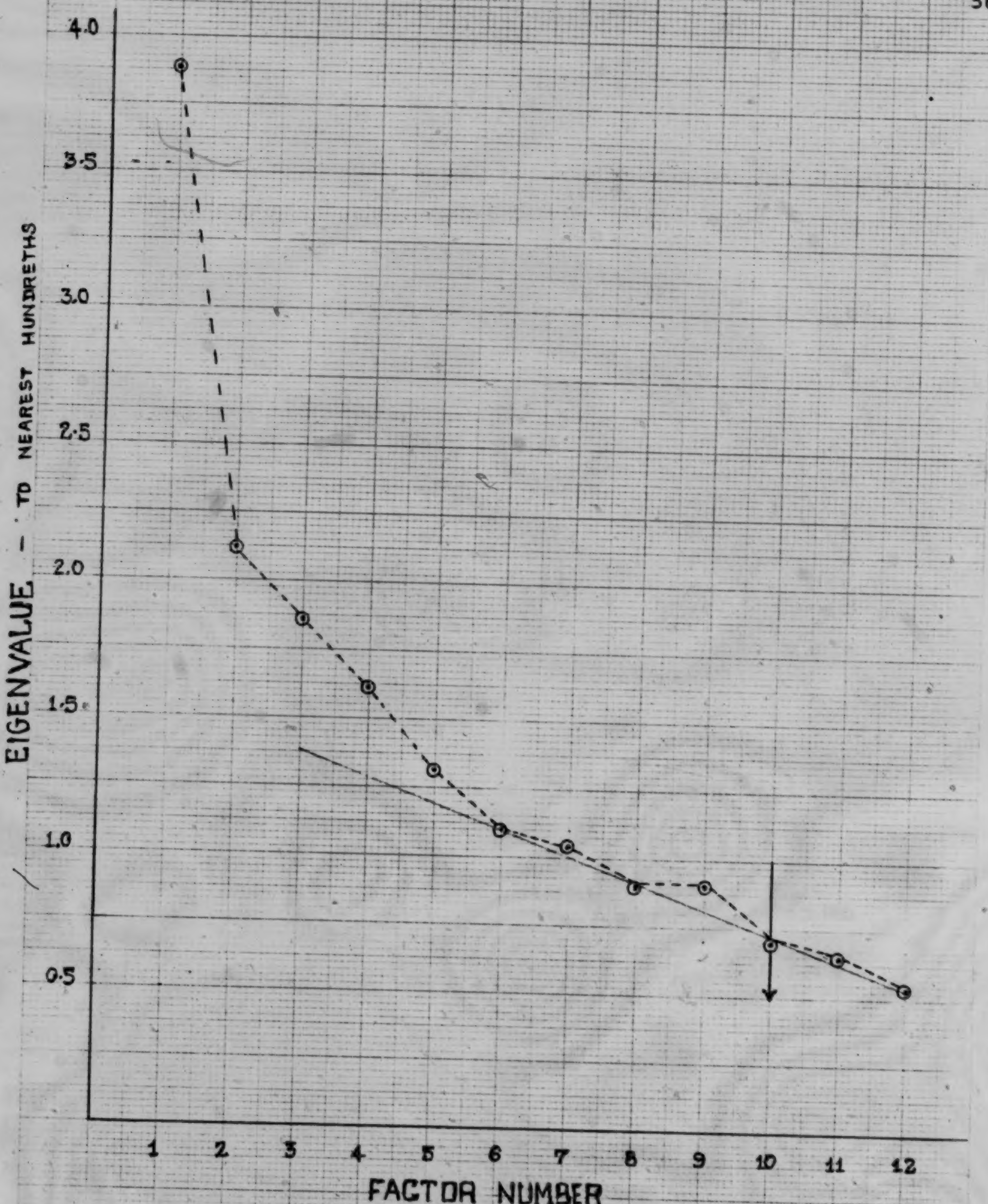
Factor loadings greater than or equal to .35 were considered significant thereby reducing the gradual intrusion of unique variance into later factors (Nie *et al.*, 1975: 473-475).

In considering the acceptability of factors, due attention was given to Kaiser's criterion (eigen values greater than one) and Cattell's Scree test. The eigen value is a special measure computed in the process of deriving a discriminant function. It is a measure of the relative importance of the function (Nie *et al.*, 1975: 442). According to Nie *et al.* (1975), there is no fixed rule for deciding what value is too small because the discriminant functions are derived in the order of their importance. Based on this, the writer therefore accepted .54 and above.

The Scree test (Figure 6.1) was utilized to determine whether eigen values less than one may be extracted by plotting the latent roots against the factor number. The point at which the curve begins to develop into a linear relationship, the maximum number of factors that may be extracted has been determined (Cattell, 1966; Child, 1970).

Therefore, to apply the Scree test, a minimum of n + 3 factors, where n represents the number of factors with eigen values greater than or equal to one, is required. The result of this test (Figure 6.1) revealed that ten of the twelve factors may be extracted for use. This result approximates the decision of the writer to accept eigen values $\geq$ .54 for use in this study.

Items from the questionnaire (see Appendix A) were grouped together by the writer to form the different scales explained in Chapter 3. Following the analysis of these items, deletions and additions were made to the items in the findings of the analysis.



CATTELL'S SCREE TEST AS APPLIED TO SECTION 'C' ITEMS

20 Squares to the Inch

Analysis of the Job Satisfaction Inventory Items

As explained later in this section, the factor analysis produced two dimensions of Job Satisfaction (Factors 1 and 4) (Table 6.1). There were five items on Factor 1 and two items on Factor 4. These two factors showed additional two items more than the ones conceived originally under the Job Satisfaction Inventory in Chapter III.

The means ranged from 4.18 to 4.97 for occupational therapists and from 4.27 to 5.18 for the physical therapists over a six point Likert-type scale (Table 6.2).

The mean item scores of the occupational therapists indicated that they were slightly to moderately satisfied with these items. For example, the therapists expressed slight satisfaction with the adequacy of their present professional qualifications and indicated moderate satisfaction with the confidence the patients had in their professional abilities.

The physical therapists, on the other hand, indicated through their means that they too were slightly to moderately satisfied with the items. They expressed slight satisfaction with the opportunities to do things that they were really educated for while they revealed moderate satisfaction with the confidence their patients placed in their

Table 6.1

Varimax Rotated Factor Matrix - Section B - Total Sample

Item No.	Factor 1	Factor 2	Factor 3	Factor 4
1	.009	.364	.004	-.045
2	.184	.595*	.130	.131
3	.469*	.504*	.086	.222
4	.155	.729*	.083	-.057
5	.100	.585*	.170	.108
6	.402*	.258	.269	.394*
7	.350*	.189	.840*	.265
8	.429*	.309	.735*	.146
9	.755*	.130	.227	.133
10	.656*	.171	.182	.023
11	.821*	.130	.096	.045
12	.290	.368*	.155	.220
13	.428*	.153	.174	.176
14	.037	-.066	.048	.697*
15	.134	.121	.140	.564*
16	.318	.008	.218	.266
Eigen Values	5.14464	1.14441	.87363	.60872
Percentage of Variance	66.2	14.7	11.2	7.8

Loading ≥ .35.

Table 6.2

Means, Standard Deviation and T Values of Items From
Job Satisfaction Scale, Occupational and Physical Therapists
(N = 130)

	Occupational Therapists $\bar{X}$	Occupational Therapists SD	Physical Therapists $\bar{X}$	Physical Therapists SD	T-Value[a]
Factor 1					
6. Your control over the quality of your work.	4.869	1.231	4.809	1.175	0.28
9. The extent to which you can use your skills.	4.623	1.098	4.603	1.351	0.09
10. The feeling of accomplishment from the work you are doing.	4.839	1.059	4.603	1.317	1.12
11. The opportunities to do things you are really educated for (as opposed to those things that people with less training can do just as well).	4.516	1.112	4.265	1.462	1.11
13. The cooperativeness you receive from other health care personnel in your institution.	4.593	1.146	4.391	1.093	1.00
Factor 4					
14. The adequacy of your present professional qualifications.	4.180	1.204	4.309	0.935	-0.67
15. The confidence in your professional ability which your patients have in you	4.966	0.669	5.179	0.737	-1.69

[a] These values are not statistically significant at $P \leq .05$.

professional abilities.

A t-test revealed no value of statistical significance at P ≤ .05. This test was used here and in other parts of this study to determine whether the observed differences in the means of the occupational and physical therapists' responses had statistically significant values.

Tables 6.3 and 6.4 revealed a breakdown of the frequency distributions to the responses of the occupational and physical therapists.

Examination of these tables showed that 95.2% of occupational therapists and 95.6% of the physical therapists showed their satisfaction with the confidence their patients placed in their professional abilities.

Intercorrelations Among Job Satisfaction Items

Pearson correlations were performed among the seven items of the Job Satisfaction scales for each group (Tables 6.5 and 6.6). It is interesting to note that both groups revealed a relatively high correlation of $\underline{r}$ = .700 for occupational therapists and $\underline{r}$ = .749 for the physical therapists for the same items (i.e., the extent to which they can use their skills and the opportunities to do things they were really educated for).

The lowest correlation of $\underline{r}$ = .038 was recorded for

Table 6.3

Frequency Distribution of the Occupational Therapists' Response to Job Satisfaction Scale (N = 62)

Category	Job Satisfaction Items						
	6	9	10	11	13	14	15
	%	%	%	%	%	%	%
1 (Very Dissatisfied)	3.2	6.5	--	3.2	--	3.2	--
2	1.6	4.8	4.8	3.2	3.2	6.5	--
3	6.5	30.6	4.8	4.8	14.5	14.5	--
4	19.4	33.9	21.0	30.6	25.8	29.0	22.6
5	30.6	22.6	40.3	43.5	25.8	35.5	53.2
6 (Very Satisfied)	37.1	1.6	29.0	14.5	25.8	9.7	19.4
Missing Cases	1.6	--	--	--	4.8	1.6	4.8

Table 6.4

Frequency Distribution of the Physical Therapists' Response to Job Satisfaction Scale (N = 68)

Category	Job Satisfaction Items						
	6	9	10	11	13	14	15
	%	%	%	%	%	%	%
1 (Very Dissatisfied)	1.5	4.4	1.5	5.9	--	--	--
2	4.4	4.4	4.4	7.4	2.9	4.4	1.5
3	5.9	8.8	19.1	16.2	19.1	11.8	1.5
4	20.6	20.6	14.7	17.6	26.5	39.7	5.9
5	35.3	32.4	27.9	30.9	29.4	36.8	58.8
6 (Very Satisfied)	32.4	29.4	32.4	22.1	16.2	7.4	30.9
Missing Cases	--	--	--	--	5.9	--	1.5

Table 6.5

Intercorrelation Matrix of Items on the Job Satisfaction Scales
Occupational Therapists (N = 62)

Items	Items													
	6		9		10		11		13		14		15	
	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2
6. Your control over the quality of your work.			.567***	.321	.339**	.115	.453***	.205	.285*	.081	.472***	.223	.392**	.154
9. The extent to which you can use your skills.					.658***	.432	.700***	.49	.292*	.085	.377**	.114	.431***	.186
10. The feeling of accomplishment from the work you are doing.							.406**	.165	.235*	.055	.101		.233*	.054
11. The opportunities to do things you are really educated for (as opposed to those things that people with less training can do just as well).									.400***	.16	.364**	.132	.321**	.103
13. The cooperativeness you receive from other health care personnel in your institution.											.141		.038	
14. The adequacy of your present professional qualifications.													.544***	.296
15. The confidence in your professional ability which your patients have in you.														

* P ≤ .05 ; ** P ≤ .01 ; *** P ≤ .001.

Table 6.6

Intercorrelation Matrix of Items on the Job Satisfaction Scales
Physical Therapists (N = 68)

Items	6		9		10		11		13		14		15	
	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2
6. Your control over the quality of your work.			.553***	.306	.529***	.280	.473***	.224	.387***	.150	.191		.596***	.355
9. The extent to which you can use your skills.					.615***	.378	.749***	.561	.406***	.165	.040		.360**	.130
10. The feeling of accomplishment from the work you are doing.							.652***	.425	.457***	.209	.053		.289**	.084
11. The opportunities to do the things you are really educated for (as opposed to those things that people with less training can do just as well).									.484***	.234	.038		.279*	.078
13. The cooperativeness you receive from other health care personnel in your institution.											.204		.237*	.056
14. The adequacy of your present professional qualifications.													.333**	.111
15. The confidence in your professional ability which your patients have in you.														

* $P \leq .05$; ** $P \leq .01$; *** $P \leq .001$.

occupational therapists between cooperativeness they received from other health care personnel and the confidence in their professional ability which their patients have in them. On the other hand, physical therapists recorded a low correlation of $r = .038$ between items dealing with the opportunity to do things they were really educated for and the cooperativeness they received from other health care personnel. The probability levels for these relationships ranged from less than or equal to .05 to $\leq .001$.

Because of the observed slight differences in the correlations and because both groups under study are members of health care personnel, the writer therefore performed a pearson correlation for the combined data (Table 6.7). It is noteworthy to report that the same items (the extent to which they can use their skills and the opportunities to do things they were really educated for) received a relatively high correlation coefficient ($r = .729$, $P = .001$). The lowest correlation $r = .068$ was recorded on the feeling of accomplishment received from their work and the adequacy of their present professional qualifications.

Validity

To measure the construct validity of the scales, a varimax rotated factor analysis based on both groups' intercorrelations among job satisfaction items was utilized.

Table 6.7

Combined Intercorrelation Matrix of Items on the Job Satisfaction Scales
Occupational and Physical Therapists (N = 130)

	Abbreviated Items						
	6 r	9 r	10 r	11 r	13 r	14 r	15 r
6 Your control over the quality of your work.		.555***	.443***	.459***	.331***	.339***	.497***
9 The extent to which you can use your skills.			.628***	.729***	.348***	.196*	.384***
10 The feeling of accomplishment from the work you are doing.				.568***	.358***	.068	.252**
11 The opportunities to do things you are really educated for (as opposed to those things that people with less training can do just as well).					.446***	.178*	.277**
13 The cooperativeness you receive from other health care personnel in your institution.						.155*	.120
14 The adequacy of your present professional qualifications.							.436***
15 The confidence in your professional ability which your patients have in you.							

* $\underline{p} \leq .05$
** $\underline{p} \leq .01$
*** $\underline{p} \leq .001$

As earlier mentioned, the job satisfaction scales items for occupational and physical therapists loaded on two factors (Factors 1 and 4) (Table 6.8). The items on Factor 1 appeared to relate to Herzberg's (1970) theory that these sets of items produce satisfaction in workers when present. Factor 4 seemed to relate to what Hoy and Miskel (1978) termed ambients in their proposed modification to Herzberg's theory. They emphasized that these ambients contained components that appeared with equal frequency as either job satisfaction or job dissatisfaction.

All the items in the two factors loaded on $\geq .402$.

Analysis of Job Dissatisfaction Inventory

Eleven questionnaire items were conceived by the author as measuring the job dissatisfaction inventory in Chapter III. Following the factor analysis, these items were reduced to five items loading on a single dimension (Factor 2) (Table 6.1).

The means, standard deviation and t-values for these scale items are given in Table 6.9. For occupational therapists, the means ranged from 3.47 to 4.66 while the means for the physical therapists ranged from 3.41 to 4.85 over a six point Likert-type scale. A clear indication from these figures confirmed that both groups have expressed slight dissatisfaction to slight satisfaction with the items. The t-test revealed no value of statistical significance at $\underline{P} \leq .05$.

Table 6.8

Factor Analysis (Varimax Rotated) of the Job Satisfaction Scales, Occupational and Physical Therapists (N = 130)

Items	Factor Loading[a]	
	Factor 1	Factor 4
6. Your control over the quality of your work.	.402	
9. The extent to which you can use your skills.	.755	
10. The feeling of accomplishment from the work you are doing.	.656	
11. The opportunities to do the things you are really educated for (as opposed to those things that people with less training can do just as well).	.821	
13. The cooperativeness you receive from other health care personnel in your institution.	.428	
14. The adequacy of your present professional qualifications.		.697
15. The confidence in your professional ability which your patients have in you.		.564
Eigen Values	5.14464	.60872
Percentage of Variance	66.2	7.8

[a] All items loaded $\geq$ .402.

Table 6.9

Means, Standard Deviation and T Values of Items From Job Dissatisfaction Scale, Occupational and Physical Therapists (N = 130)

Items	Occupational Therapists $\overline{X}$	Occupational Therapists SD	Physical Therapists $\overline{X}$	Physical Therapists SD	T-Value[a]
Factor 2					
1. The conditions under which you have to work (i.e., lighting, ventillation, space and equipment).	3.721	1.253	4.015	1.419	-1.24
2. The opportunities for advancement in your position.	3.468	1.445	3.635	1.517	-0.63
4. The amount of pay you get for doing your job.	3.468	1.576	3.409	1.559	0.21
5. The amount of job security you have in your position.	4.656	1.167	4.851	1.222	-0.92
12. The extent to which the medical doctors accept you as a collegue within the health care system.	3.700	1.306	4.015	1.430	-1.29

[a] These values are not statistically significant at $\underline{P} \leq .05$.

Examination of Tables 6.10 and 6.11 which indicate the frequency distributions of the scale items revealed that both groups tended to be satisfied with the job security in their respective positions (83.9% for occupational therapists and 89.7% for physical therapists). 45.2% of the occupational therapists showed a slight to moderate dissatisfaction with the opportunities for advancement in their positions while 50% of the physical therapists indicated a slight to moderate dissatisfaction with the amount of pay they received for doing their job. The t-test performed on the means revealed no value of statistical significance at $P \leq .05$ level.

Intercorrelation Among Job Dissatisfaction Items

Separate Pearson correlations were performed among the five items of the scale for each group (Tables 6.12 and 6.13). The intercorrelations among the five items of the job dissatisfaction scale were low. For occupational therapists, these range from $\underline{r} = .008$ to $\underline{r} = .397$, $\underline{P} \leq .01$ and for physical therapists from $\underline{r} = .269$, $\underline{P} \leq .05$ to $\underline{r} = .631$, $\underline{P} \leq .001$. The r^2 indicates common variance.

Occupational therapists recorded their highest correlation of $\underline{r} = .397$ between the amount of job security they have and the extent to which the medical doctors accepted them as colleagues. Their lowest correlation $\underline{r} = .008$ was found between the conditions under which they had to work and the amount of job security they had.

Table 6.10

Frequency Distribution of the Occupational Therapists' Response to Job Dissatisfaction Scale (N = 62)

Category	Job Dissatisfaction Items 1 %	2 %	4 %	5 %	12 %
1 (Very Dissatisfied)	6.5	9.7	11.3	1.6	1.6
2	6.5	21.0	22.6	4.8	19.4
3	25.8	14.5	17.7	8.1	21.0
4	38.7	30.6	14.5	19.4	30.6
5	11.3	16.1	24.2	41.9	12.9
6 (Very Satisfied)	9.7	8.1	9.7	22.6	11.3
Missing Cases	1.6	--	--	1.6	3.2

Table 6.11

Frequency Distribution of the Physical Therapists' Response to Job Dissatisfaction Scale (N = 68)

Category	Job Dissatisfaction Items 1 %	2 %	4 %	5 %	12 %
1 (Very Dissatisfied)	2.9	10.3	10.3	2.9	7.4
2	13.2	11.8	25.0	4.4	10.3
3	22.1	19.1	14.7	1.5	10.3
4	22.1	23.5	19.1	20.6	29.4
5	20.6	16.2	17.6	35.3	27.9
6 (Very Satisfied)	19.1	11.8	10.3	33.8	13.2
Missing Cases	--	7.4	2.9	1.5	1.5

Table 6.12

Intercorrelation Matrix of Items on the Job Dissatisfaction Scale
Occupational Therapists (N = 62)

Items	Items 1 r	Items 1 r^2	Items 2 r	Items 2 r^2	Items 4 r	Items 4 r^2	Items 5 r	Items 5 r^2	Items 12 r	Items 12 r^2
1. The conditions under which you have to work (i.e., lighting, ventillation, space and equipment).			-.148		$.300^{**}$	.09	.008		-.016	
2. The opportunities for advancement in your position.					$.356^{**}$	.127	$.339^{**}$	.115	$.357^{**}$	.127
4. The amount of pay you get for doing your job.							$.347^{**}$	.120	.148	
5. The amount of job security you have in your position.									$.397^{**}$	.158
12. The extent to which the medical doctors accept you as a colleague within the health care system.										

** $\underline{P} \le .01$.

Table 6.13

Intercorrelation Matrix of Items on the Job Dissatisfaction Scale
Physical Therapists (N = 68)

Items	Items									
	1		2		4		5		12	
	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2
1. The conditions under which you have to work (i.e., lighting, ventillation, space and equipment).			.420***	.176	.269*	.072	.287**	.082	.305**	.093
2. The opportunities for advancement in your position.					.486***	.236	.354**	.125	.289*	.084
4. The amount of pay you get for doing your job.							.631***	.398	.385**	.148
5. The amount of job security you have in your position.									.333**	.111
12. The extent to which the medical doctors accept you as a colleague within the health care system.										

* $\underline{P} \leq .05$.
** $\underline{P} \leq .01$.
*** $\underline{P} \leq .001$.

Physical therapists on the other hand had a relatively high correlation of $\underline{r} = .631$ between the amount of pay they got and the amount of job security in their positions. Their lowest correlation $\underline{r} = .269$ was recorded between the conditions under which they had to work and the amount of pay they received.

The data were combined for both groups for the same reasons offered earlier (Table 6.14). An examination of this table revealed a relatively high correlation ($\underline{r} = .488$, $\underline{P} \leq .001$) between the amount of pay they received and the amount of job security in their positions. A low correlation of $\underline{r} = .167$, $\underline{P} \leq .05$ existed between the conditions under which they worked and the opportunities for advancement in their positions.

Validity

In measuring the construct validity of the scale items, a varimas rotated factor analysis based on the combined intercorrelations among job dissatisfaction items was employed. As explained earlier, this scale loaded on a single dimension (Factor 2) Table 6.15). With the items loading beyond .364, further support was given to Herzberg's (1971) theory that these sets of items called "hygienes" produced dissatisfaction when absent.

Table 6.14

Combined Intercorrelations Matrix of Items on the Job Dissatisfaction Scale
Occupational and Physical Therapists (N = 130)

Items	Items 1 r	 2 r	 4 r	 5 r	 12 r
1. The conditions under which you have to work (i.e., lighting, ventillation, space and equipment).		.167*	.279**	.175*	.183*
2. The opportunities for advancement in your position.			.419***	.349***	.323***
4. The amount of pay you get for doing your job.				.488***	.272**
5. The amount of job security you have in your position.					.366***
12. The extent to which the medical doctors accept you as a collegue within the health care system.					

* $\underline{P} \leq .05$
** $\underline{P} \leq .01$
*** $\underline{P} \leq .001$

Table 6.15

Factor Analysis (Varimax Rotated) of the Job Dissatisfaction Scale, Occupational and Physical Therapists (N = 130)

Items	Factor Loading[a]
	Factor 2
1. The conditions under which you have to work (i.e., lighting, ventillation, space and equipment)	.364
2. The opportunities for advancement in your position	.595
4. The amount of pay you get for doing your job	.729
5. The amount of job security you have in your position	.585
12. The extent to which the medical doctors accept you as a colleague within the health care system	.368
Eigen Values	1.14441
Percentage of Variance	14.7

[a] Items with loading $\geq$ .364.

Analysis of the Professional Role Autonomy Scale

Thirteen items were originally conceived by the author for this scale in Chapter III. Following the factor analysis, these items were reduced to six, loading on two dimensions (Factors 1 and 2) (Table 6.16).

The means, standard deviations and t-values for the scale items are given in Table 6.17. For occupational therapists the means ranged from 4.07 to 5.53 indicating that this group expressed slight to moderate agreement with the scale items.

For the physical therapists the means ranged from 3.31 to 5.42. These indicate that this group, too, expressed slight to moderate agreement with the scale items. The t-test performed on the scale revealed three items (Nos. 3, 4 and 7) having values of statistical significance between $\underline{P} \leq .05$ to $\underline{P} \leq .01$ levels (Table 6.17). Of particular note is the issue of the therapists providing their services to clients without the requirement of a physician's referral or prescription. The occupational therapists' responses to this item indicate a higher significant agreement with the statement than the physical therapists.

Examination of Tables 6.18 and 6.19 revealed the frequency distributions of the scale items. Table 6.18 indicated that occupational therapists recorded their overwhelming agreement (96.8%) with responsibility to develop staff projections for their departments. The highest

Table 6.16

Varimax Rotated Factor Matrix - Section C - Total Sample

Item No.	Factors											
	1	2	3	4	5	6	7	8	9	10	11	12
1	.614*	.140	-.035	.138	-.054	.110	.083	-.036	.062	.018	-.027	-.059
2	-.399*	-.004	-.354*	.309	.017	-.153	-.133	-.417*	.142	.062	.151	.061
3	.254	.805*	-.070	-.072	.060	.029	.115	.051	-.031	.068	.076	-.108
4	.025	.914*	.077	-.021	.102	.093	.067	.105	.079	.027	-.058	.024
5	.435*	.405*	.092	.297	-.005	.024	.048	.090	.167	-.126	-.076	.215
6	.448*	.238	.216	.017	.176	.081	-.032	-.057	-.014	-.157	.261	.150
7	.712*	.030	.148	-.213	.042	.136	-.029	.187	-.063	.080	.106	-.278
8	.686*	.038	-.041	.175	.121	-.110	-.093	.113	-.029	.020	-.137	-.011
9	.054	.040	.112	-.092	-.026	[illegible]	.305	.100	-.193	-.051	-.158	.325
10	.133	.011	-.282	.075	.151	.073	.253	.264	.234	.322	.029	.338
11	.040	.052	-.068	.026	.159	.087	.349	.355*	.176	-.089	.263	.168
12	.062	.187	.006	.297	.065	-.012	.898*	.030	-.016	.030	-.124	.009
13	-.057	.166	-.582*	.078	.046	.088	-.049	.119	-.174	-.019	-.022	-.161
14	.123	-.041	.341	.575*	-.029	-.037	.112	.235	-.188	-.003	-.111	.066
15	.061	.117	.077	.543*	.058	.103	.054	.138	.070	.056	.041	.056
16	.120	.135	-.033	.143	.059	.014	.025	.659*	-.030	-.152	-.056	-.060
17	.045	.104	-.437	-.122	-.047	-.027	.039	.061	-.323	.182	.202	-.118
18	-.073	-.013	.147	-.025	-.082	-.074	-.088	-.040	.010	-.034	.658*	.046
19	.289	.064	-.070	.079	-.070	.009	-.004	.092	.026	.018	-.129	-.534*
20	-.027	-.033	.013	.081	-.034	.125	.024	.220	.072	-.682*	.032	.027
21	.171	.070	-.073	.281	-.036	.238	.011	.085	.274	-.083	-.075	.039
22	.075	.040	.069	.067	.023	.812*	.057	.043	.008	-.082	-.064	.005
23	.074	.123	.049	-.484*	.064	.110	.009	.178	-.196	.068	-.054	.148
24	.046	.097	.028	.035	.057	.063	-.032	-.019	.542*	-.055	.028	-.030
25	-.142	-.117	-.101	-.002	-.164	-.197	.063	.017	.388*	.211	.020	-.037

(cont'd...)

Table 6.16 (cont'd)

Item No.	Factors											
	1	2	3	4	5	6	7	8	9	10	11	12
26	-.171	.125	.001	-.508*	.001	-.168	-.221	.031	.075	.090	.067	.197
27	-.022	.282	-.210	.335	-.161	.401*	-.045	.156	.140	.412*	-.183	.010
28	-.026	.049	.627*	.083	.048	.154	-.071	.086	-.091	.007	.185	-.094
29	.083	.288	.622*	.124	.028	.005	.058	.016	-.200	-.045	.122	.001
30	.119	.199	.113	-.048	.665*	.104	.076	-.036	.153	.126	-.091	.084
31	-.022	-.021	-.062	.023	.802*	-.059	.017	.119	-.108	-.076	-.004	-.003

Factor	Eigen Value	Pct. of Variance
1	3.88992	23.4
2	2.11602	12.7
3	1.87076	11.2
4	1.61273	9.7
5	1.32007	7.9
6	1.10363	6.6
7	1.04378	6.3
8	0.90045	5.4
9	0.86717	5.2
10	0.70869	4.3
11	0.64746	3.9
12	0.54942	3.3

Loading $\leq$ .354

Table 6.17

Means, Standard Deviation and T-Values of Items from Role Autonomy Scales, Occupational and Physical Therapists (N=130)

Items	Occupational Therapists $\overline{X}$	Occupational Therapists SD	Physical Therapists $\overline{X}$	Physical Therapists SD	T-Value
Factor 1					
1. Occupational/physical therapists should be permitted to terminate or continue treatment of their patients as they deem fit.	5.177	.859	5.418	.907	-1.54
6. Occupational/physical therapists as members of a health care team should be allowed to function more independently.	4.983	1.025	4.761	1.143	1.14
7. Occupational/physical therapists within medical settings should be allowed to provide their services to clients in need of those services without the requirement of a physician's referral or prescription.	4.065	1.535	3.309	1.595	2.75**
8. Occupational/physical therapists should be allowed to make their own decisions regarding problems that come up with the treatment of their patients.	4.803	1.166	4.5672	1.270	1.09

(cont'd...)

Table 6.17 (cont'd)

Items	Occupational Therapists $\overline{X}$	Occupational Therapists SD	Physical Therapists $\overline{X}$	Physical Therapists SD	T-Value
Factor 2					
3. Occupational/physical therapists should be responsible for developing the budget for occupational/physical therapy departments in their facilities.	5.393	.802	5.030	1.215	1.97*
4. Occupational/physical therapists should be responsible for developing staff projections for the occupational/physical therapy departments in their facilities.	5.525	.744	5.182	1.149	2.01*

* $\underline{P} \leq .05$

** $\underline{P} \leq .01$

Table 6.18

Frequency Distribution of the Occupational Therapists' Response to Professional Role Autonomy Scales (N = 62)

Category	Role Autonomy Items					
	1	3	4	6	7	8
	%	%	%	%	%	%
1 (Strongly Disagree)	--	--	--	--	6.5	--
2	1.6	--	--	3.2	16.1	4.8
3	3.2	1.6	1.6	3.2	8.1	9.7
4	9.7	14.5	9.7	21.0	21.0	19.4
5	46.8	25.8	22.6	32.3	30.6	30.6
6 (Strongly Agree)	38.7	56.5	64.5	35.5	17.7	33.9
Missing Values	--	1.6	1.6	4.8	--	1.6

Table 6.19

Frequency Distribution of the Physical Therapists' Response to Professional Role Autonomy Scales (N = 68)

Category	Role Autonomy Items					
	1	3	4	6	7	8
	%	%	%	%	%	%
1 (Strongly Disagree)	--	2.9	2.9	2.9	16.2	2.9
2	1.5	1.5	--	1.5	14.7	4.4
3	1.5	4.4	5.9	5.9	29.4	10.3
4	14.7	17.6	8.8	22.1	14.7	22.1
5	17.6	25.0	29.4	39.7	11.8	33.8
6 (Strongly Agree)	63.2	45.6	50.0	26.5	13.2	25.0
Missing Values	1.5	2.9	2.9	1.5	--	1.5

percentage of their disagreement (30.7%) was found with the issue of providing their services to clients without the need for physician's referral or prescription.

Table 6.19 also revealed that 95.5% of the physical therapists agreed that they should be permitted to terminate or continue treatment of their patients as they deemed fit. On the other hand, 60.3% disagreed with the notion that their services be given without physician's referral or prescription.

Intercorrelation Among Professional Role Autonomy Items

As done with the other scale items, Pearson correlations were performed on the responses of the groups separately (Tables 6.20 and 6.21).

The intercorrelations among the six items of the scale for occupational therapists were generally low as indicated by their variances (Table 6.20). These range from $\underline{r} = .079$ to $\underline{r} = .821$, $\underline{P} \leq .001$. The lowest correlation $\underline{r} = .079$ was found between the therapists being responsible for the development of staff projections in their departments and being allowed to provide their services to clients without the need for physician's referral or prescription. A relatively high correlation of $\underline{r} = .821$, $\underline{P} \leq .001$ was found between the therapists expressing the desire to develop their own budget and the staff projections for their departments.

Table 6.20

Intercorrelation Matrix of Items on the Professional Role Autonomy Scales
Occupational Therapists (N = 62)

Items	1		3		4		6		7		8	
	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2
1. Occupational/physical therapists should be permitted to terminate or continue treatment of their patients as they deem fit.			.304**	.092	.109		.330**	.109	.240*	.058	.415**	.172
3. Occupational/physical therapists should be responsible for developing the budget for occupational/physical therapy departments in their facilities.					.821***	.674	.237*	.056	.100		.155	
4. Occupational/physical therapists should be responsible for developing staff projections for the occupational/physical therapy departments in their facilities.							.181		.079		.085	
6. Occupational/physical therapists as members of a health care team should be allowed to function more independently.									.164		.541***	.293
7. Occupational/physical therapists within medical settings should be allowed to provide their services to clients in need of those services without the requirement of a physician's referral or prescription.											.460***	.212
8. Occupational/physical therapists should be allowed to make their own decisions regarding problems that come up with the treatment of their patients.												

* $\underline{P} \leq .05$; ** $\underline{P} \leq .01$; *** $\underline{P} \leq .001$.

Table 6.21

Intercorrelation Matrix of Items on the Professional Role Autonomy Scales
Physical Therapists (N = 68)

Items	1		3		4		6		7		8	
	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2
1. Occupational/physical therapists should be permitted to terminate or continue treatment of their patients as they deem fit.			.335**	.112	.160		.360**	.130	.423***	.179	.528***	.279
3. Occupational/physical therapists should be responsible for developing the budget for occupational/physical therapy departments in their facilities.					.723***	.523	.368**	.135	.231*	.053	.249*	.062
4. Occupational/physical therapists should be responsible for developing staff projections for the occupational/physical therapy departments in their facilities.							.347**	.120	.027		.052	
6. Occupational/physical therapists as members of a health care team should be allowed to function more independently.									.500***	.25	.138	
7. Occupational/physical therapists within medical settings should be allowed to provide their services to clients in need of those services without the requirement of a physician's referral or prescription.											.384**	.147
8. Occupational/physical therapists should be allowed to make their own decisions regarding problems that come up with the treatment of their patients.												

* $\underline{P} \leq .05$; ** $\underline{P} \leq .01$; *** $\underline{P} \leq .001$.

Table 6.21 revealed that Pearson correlations the physical therapists' responses were generally low. These range from $r = .027$ to $r = .723$, $P \leq .001$.

A relatively high correlation $r = .723$, $P \leq .001$ was found between the therapists wanting to take responsibility for the development of their departmental budget and the staff projections. The lowest correlation $r = .027$ was found to exist between the physical therapists' desire to take responsibility for the development of staff projections and providing their services to clients in need of those services without the physician's referral or prescription.

When the data were combined (Table 6.22), the correlations did not differ significantly from the separate intercorrelations for the two groups. These correlations ranged from $r = .077$ to $r = .759$, $P \leq .001$. It is interesting to discover that the highest correlation ($r = .759$, $P \leq .001$) existed between the same items in which the two groups separately recorded their highest correlations (i.e., responsibility to develop their budget and staff projections for their departments).

The low correlation of $r = .077$ existed between the therapists developing their staff projections and being allowed to make their decisions regarding problems that came up with the patients' treatment.

Table 6.22

Combined Intercorrelations Matrix of Items on the Professional Role Autonomy Scales Occupational and Physical Therapists (N = 130)

	Items					
	1 r	3 r	4 r	6 r	7 r	8 r
1. Occupational/Physical therapists should be permitted to terminate or continue treatment of their patients as they deem fit.		.287**	.112	.328***	.294***	.458***
3. Occupational/Physical therapists should be responsible for developing the budget for occupational/physical therapy departments in their facilities.			.759***	.331***	.212**	.223**
4. Occupational/Physical therapists should be responsible for developing staff projections for the occupational/physical therapy departments in their facilities.				.301***	.083	.077
6. Occupational/Physical therapists as members of a health care team should be allowed to function more independently.					.366***	.316***
7. Occupational/Physical therapists within medical settings should be allowed to provide their services to clients in need of those services without the requirement of a physician's referral or prescription.						.427***
8. Occupational/Physical therapists should be allowed to make their own decisions regarding problems that come up with the treatment of their patients.						

** $\underline{P} \le .01$; *** $\underline{P} \le .001$.

Validity

To measure the construct validity of the scales' items, a varimax rotated factor analysis based on the combined intercorrelations among the professional role autonomy items was utilized.

As noted earlier, the scales loaded on two dimensions (Factors 1 and 2) (Table 6.23). The items on the two factors appeared to measure the concept of role autonomy scale originally conceived by the writer in Chapter III.

Analysis of the Professional Knowledge Scales

Before the factor analysis, nine items were deemed by the writer to measure the knowledge scale accounted for in Chapter III. Following the factor analysis, twelve items loading on five dimensions (Factors 3, 4, 8, 10 and 11) were found to come under this rubric (Table 6.16). Details will be explained later in this section.

The means, standard deviation and T-values for the items are given in Table 6.24. For occupational therapists, the means ranged from 1.84 to 5.77 indicating that the group respondents showed moderate disagreement to high agreement with the items.

The means for the physical therapists ranged from 2.02 to 5.82 indicating that they too showed moderate disagreement to high agreement with the items.

Table 6.23

Factor Analysis (Varimax Rotated) of the
Professional Role Autonomy Scales
Occupational and Physical Therapists (N = 130)

Items	Factor Loading[a]	
	Factor 1	Factor 2
1. Occupational/physical therapists should be permitted to terminate or continue treatment of their patients as they deem fit.	.614	
3. Occupational/physical therapists should be responsible for developing the budget for occupational/physical therapy departments in their facilities.		.805
4. Occupational/physical therapists should be responsible for developing staff projections for the occupational/physical therapy departments in their facilities.		.914
6. Occupational/physical therapists as members of a health care team should be allowed to function more independently.	.448	
7. Occupational/physical therapists within medical settings should be allowed to provide their services to clients in need of those services without the requirement of a physician's referral or prescription.	.712	
8. Occupational/physical therapists should be allowed to make their own decisions regarding problems that come up with the treatment of their patients.	.686	
Eigen Values	3.88992	2.11602
Percentage of Variance	23.4	12.7

[a] All items loaded $\geq .448$.

Table 6.24

Means, Standard Deviation and T-Values of Items from Professional Knowledge Scales, Occupational and Physical Therapists (N = 130)

Items	Occupational Therapists		Physical Therapists		T-Value
	$\overline{X}$	SD	$\overline{X}$	SD	
Factor 3					
13[a] To what extent do you agree that occupational therapy as a profession has a firm core of theory and knowledge like medicine?	3.968	1.267	4.544	1.152	-2.71**
17. To what extent do you agree that university education in occupational/physical therapy is adequate?	3.574	1.132	4.147	1.225	-2.75**
28. Do you agree that occupational/physical therapy as a profession may be threatened by the growth and development of other occupations or professions?	4.246	1.491	3.603	1.746	2.24*
29. To what extent do you agree that the lack of a clearly defined area of competence in relation to other health professions account for some of the problems in occupational/physical therapy profession?	4.629	1.333	4.194	1.270	1.90
Factor 4					
14. I sometimes do things that I should have been better prepared for in my course in occupational/physical therapy.	4.754	1.274	4.397	1.457	1.47
15. Continuing education in occupational/physical therapy should be developed to meet the needs of the therapists.	5.774	.459	5.824	.384	-0.67

(cont'd...)

Table 6.24 (cont'd)

	Occupational Therapists		Physical Therapists		
	$\overline{X}$	SD	$\overline{X}$	SD	T-Value
Factor 4 (cont'd)					
23[a] To what extent did you agree that occupational/physical therapy training prepared you to conduct and report research?	2.548	1.410	2.343	1.262	0.87
26[a] My occupational/physical therapy education prepared me adequately to carry out administrative/supervisory duties.	2.371	1.177	2.382	1.383	-0.05
Factor 8					
11. Membership in the national association should be a requirement to practise or hold a position.	4.548	1.445	4.353	1.717	.70
16. Thinking of various jobs which occupational/physical therapists may hold five to ten years from now, Alberta would need a Master's program in occupational/physical therapy.	4.855	1.545	4.000	1.828	2.86
Factor 10					
20[a] I feel the need for someone with a higher level of expertise in occupational/physical therapy in my facility.	3.183	1.557	3.313	1.877	-0.42
Factor 11					
18. To what extent do you agree that occupational/physical therapy education in a community college could be adequate to meet the training requirements of the professions?	1.836	1.157	2.015	1.377	-0.79

[a] Reflected Item; * $P \leq .05$; ** $P \leq .01$.

The t-test revealed three items (Nos. 13[a], 17 and 28) having values of statistical significance between $\underline{P} \leq .05$ and $\underline{P} \leq .01$. For example, occupational therapists differed significantly in their opinions from the physical therapists on the issue of whether the professions possessed a firm core of theory and knowledge like medicine. While the occupational therapists expressed very slight agreement, the physical therapists indicated almost moderate agreement with the issue.

Examination of Tables 6.25 and 6.26 revealed the frequency distributions of the scale items. Table 6.25 showed that 100% of the occupational therapy respondents indicated their approval for the encouragement of continuing education in the profession while 88.1% of the same respondents expressed their disapproval for having community colleges to educate members of the profession.

Table 6.26 interestingly revealed 100% agreement among the physical therapists for the encouragement of continuing education in the profession while 86.8% registered their disagreement for having community colleges to educate members of the profession.

Intercorrelation Among Professional Knowledge Scale Items

Separate Pearson correlations were computed for all the twelve items of the scales for each group (Tables 6.27 and 6.28). For occupational therapists, intercorrelations

Table 6.25
Frequency Distribution of the Occupational
Therapists' Response to Professional Knowledge Scales
(N = 62)

Category	Professional Knowledge Scales											
	11 %	13[a] %	14 %	15 %	16 %	17 %	18 %	20[a] %	23[a] %	26[a] %	28 %	29 %
1 (Strongly Disagree)	3.2	4.8	3.2	--	3.2	4.8	53.2	12.9	32.3	27.4	6.5	3.2
2	6.5	9.7	1.6	--	9.7	12.9	24.2	29.0	24.2	33.9	9.7	6.5
3	17.7	11.3	11.3	--	8.1	22.6	9.7	16.1	9.7	16.1	11.3	6.5
4	11.3	43.5	17.7	1.6	11.3	38.7	6.5	11.3	24.2	19.4	16.1	22.6
5	27.4	19.4	30.6	19.4	12.9	17.7	4.8	21.0	9.7	3.2	35.5	30.6
6 (Strongly Agree)	33.9	11.3	33.9	79.0	54.8	1.6	--	6.5	--	--	19.4	30.6
Missing Values	--	--	1.6	--	--	1.6	1.6	3.2	--	--	1.6	--

Table 6.26
Frequency Distribution of the Physical
Therapists' Response to the Professional Knowledge Scales
(N = 68)

	Professional Knowledge Scales											
	11 %	13[a] %	14 %	15 %	16 %	17 %	18 %	20[a] %	23[a] %	26[a] %	28 %	29 %
1 (Strongly Disagree)	5.9	1.5	7.4	--	13.2	4.4	51.5	25.0	29.4	33.8	16.2	1.5
2	16.2	2.9	2.9	--	13.2	2.9	20.6	16.2	32.4	26.5	17.6	8.8
3	8.8	13.2	11.8	--	14.7	20.6	14.7	11.8	19.1	20.6	11.8	16.2
4	16.2	26.5	26.5	--	8.8	29.4	5.9	11.8	10.3	8.8	14.7	33.8
5	11.8	33.8	23.5	17.6	19.1	30.9	2.9	16.2	5.9	7.4	23.5	19.1
6 (Strongly Agree)	41.2	22.1	27.9	82.4	30.9	11.8	4.4	17.6	1.5	2.9	16.2	19.1
Missing Values	--	--	--	--	--	--	--	1.5	1.5	--	--	1.5

[a] Reflected Item

	Items																							
	11		13^{a}		14		15		16		17		18		20^{a}		23^{a}		26^{a}		28		29	
Items	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2
11			-.073		.216*	.047	.214*	.046	.161		.007		.022		-.272		.067		.064		-.009		.056	
13^{a}					.064		.069		-.316**	.100	-.165		-.092		.095		.120		.019		.258*	.067	.308**	.095
14							.469***	.220	.160		-.151		-.005		.015		.199		.360**	.130	.086		.344**	.118
15									.231*	.053	-.190		-.134		-.107		.287*		.359**	.129	.253*	.064	.236*	.056
16											.063		.000		-.347**	.120	-.203	.041	-.021		-.026		.058	
17													.073		-.027		-.302**	.091	-.128		.139		.207	
18															-.233*	.054	.085	.007	-.048		.210		.087	
20^{a}																	.222*	.049	.047		-.091		.020	
23^{a}																			.024		.023		.038	
26^{a}																					.040		.193*	.037
28																							.612***	.375
29																								

[a] Reflected Item.

* $p \leq .05$.

** $p \leq .01$.

*** $p \leq .001$.

Table 6.27

Intercorrelation Matrix of Items on the Professional Knowledge Scales
Occupational Therapists (N = 62)

Items	11		13^a		14		15		16		17		18		20^a		23^a		26^a		28		29	
	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2
11			-.022		-.081		-.063		.228*	.052	-.018		.055		-.019		-.073		-.093		-.092		-.023	
13^a					-.083		-.153		-.121		-.429***	.184	.128		-.077		.052		.027		.121		.381**	.145
14							.127		.219*	.048	-.167		-.033		-.018		.098		.269*	.072	.063		-.000	
15									.106		.024		-.052		.026		.121		.124		.005		-.052	
16											.047		-.030		-.136		-.113		.077		-.023		.009	
17													.052		.202		-.161		-.063		-.224*	.050	-.281*	.079
18															.056		-.153		-.256*	.066	.238*	.057	-.066	
20^a																	-.114		-.123		-.250*	.063	-.123	
23^a																			.337**	.114	-.069		.017	
26^a																					.017		.121	
28																							.258*	.067
29																								

^{a}Reflected Item.
*$p < .05$.
**$p \leq .01$.
***$p \leq .001$.

Table 6.28

Intercorrelation Matrix of Items on the Professional Knowledge Scales
Physical Therapists (N = 68)

among the items were generally low (Table 6.27). These range from r = .000 to r = .612, P ≤ .001. The highest correlation (r = .612, P ≤ .001) was found between their perceived threat of the growth and development of other occupations or professions to their profession and the extent to which they agreed that the lack of a clearly defined area of competence accounted for some of the problems in their profession. The absence of correlation of r = .000 was found between the therapists' need for a Master's program in the future and their agreement with the adequacy of a community college to meet their training requirements.

The Pearson correlations to physical therapists' responses on the knowledge scales were also generally low (Table 6.28). They range from r = .000 to r = -.429, P ≤ .001. The relatively high negative correlation of r = -.429 was found between the therapists' degree of agreement with their profession having a firm core of theory and knowledge like medicine and the extent of their agreement with the adequacy of a university education in the profession. The absence of correlation of r = -.000 existed between the therapists' agreement for doing things they should have been better prepared for in their physical therapy course and the extent of their agreement with the lack of a clearly defined area of competence as accounting for some of the problems in the profession.

When the data were combined for the same stated reasons given earlier, the correlations ranged from $\underline{r} = .009$ to $\underline{r} = .497$, $\underline{P} \leq .001$ (Table 6.29). The highest correlation noted here was found to exist between the respondents' extent of agreement with the issue that membership in the national association should be a requirement to practice or hold a position and with their feeling of having someone with a higher level of expertise in their facilities. The very low correlation of $\underline{r} = .009$ existed between the extent of their agreement with the professions needing a Master's program in the future and the extent of their agreement with the lack of a clearly defined area of competence as accounting for some of the problems in their professions.

Validity

In measuring the construct validity of items of the scales, a varimax rotated factor analysis based on the combined intercorrelations was utilized. As described before, these items loaded on five dimensions (Factors 3, 4, 8, 10 and 11) (Table 6.30). A closer examination of these items revealed that they seemed to measure the knowledge dimension originally conceived by the writer in Chapter III.

With all the items loading $\geq .355$, they appear to give credence to the theories of Pavalko (1971) and Goode in Etzioni (1969) that professional knowledge was one of the characteristics of professionalism.

Table 6.29

Combined Intercorrelations Matrix of Items on the Professional Knowledge Scales
Occupational and Physical Therapists
(N = 130)

Abbreviated Items	11	13^a	14	15	16	17	18	20^a	23^a	26^a	28	29
11		.029	.044	.065	.210**	-.021	.038	.497***	.094	.143	-.154*	.122
13^a			-.015	.045	.139	.340***	-.012	.401***	-.028	-.068	-.053	-.076
14				.278**	.220**	-.184*	-.029	.384***	-.043	.106	-.122	.190*
15					.144*	-.065	-.084	.252**	-.041	-.102	-.150*	.106
16						-.012	-.036	.277**	-.060	-.085	-.153*	.009
17							.075	.247**	.164*	-.068	-.259**	-.119
18								.120	-.074	-.207*	-.016	-.018
20^a									.037	.058	.177*	.055
23^a										.188*	.039	-.015
26^a											-.028	-.020
28												.434***
29												

[a] Reflected Item

$^{*}r = \leq .05$
$^{**}r = \leq .01$
$^{***}r = \leq .001$

Table 6.30

Factor Analysis (Varimax Rotated) of Professional Knowledge Scales Occupational and Physical Therapists (N = 130)

	Items	Factor Loading[a]
	Factor 3	
13a	To what extent do you agree that occupational/physical therapy as a profession has a firm core of theory and knowledge like medicine?	-.582
17.	To what extent do you agree that university education in occupational/physical therapy is adequate?	.437
28.	Do you agree that occupational/physical therapy as a profession may be threatened by the growth and development of other occupations or professions?	.627
29.	To what extent do you agree that the lack of a clearly defined area of competence in relation to other health professions account for some of the problems in occupational/physical therapy profession?	.622
	Factor 4	
14.	I sometimes do things that I should have been better prepared for in my course in occupational/physical therapy.	.575
15.	Continuing education in occupational/physical therapy should be developed to meet the needs of the therapists.	.543
23[a]	To what extent did you agree that occupational/physical therapy training prepared you to conduct and report research?	-.484
26[a]	My occupational/physical therapy education prepared me adequately to carry out administrative/supervisory duties.	-.508

(cont'd...)

Table 6.30 (cont'd)

Items	Factor Loading[a]
Factor 8	
11. Membership in the national association should be a requirement to practice or hold a position.	-.355
16. Thinking of various jobs which occupational/physical therapists may hold five to ten years from now, Alberta would need a Master's program in occupational/physical therapy.	.659
Factor 10	
20[a] I feel the need for someone with a higher level of expertise in occupational/physical therapy in my facility.	-.682
Factor 11	
18. To what extent do you agree that occupational/physical therapy education in a community college could be adequate to meet the training requirements of the profession?	.658

	3	4	8	10	11
Eigen Values	1.87076	1.61273	.90045	.86717	.64746
Percentage of Variance	11.2	9.7	5.4	5.2	3.9

[a] All items loaded ≥ .355.

Analysis of the Service Ideal Scales

Nine items were originally accounted for in Chapter III as measuring a service ideal scale. Following factor analysis, seven items were found to load on five dimensions (Factors 5, 6, 7, 9, and 12) (Table 6.16). Details will be given later in this section.

The means, standard deviation and T-values for the items are given in Table 6.31. The means ranged from 3.09 to 5.33 for occupational therapists and from 3.03 to 4.99 for physical therapists over a six point Likert-type scale.

The occupational therapists have indicated from these means that they slightly disagreed to moderately agreed with the items on the scales. The physical therapists also indicated the same degree of disagreement/agreement. The t-test revealed no value of statistical significance.

The frequency distributions of these items are given in Tables 6.32 and 6.33. Table 6.32 revealed 90.4% of the occupational therapists favoring the re-examination and relicensing for any therapist who wished to re-enter practice after an absence of five years or more while 58.1% of the same group disagreed that occupational therapists be evaluated by fellow therapists.

Table 6.33 showed that physical therapists substantially agreed (89.7%) to the re-examination and relicensing for any therapist who wished to re-enter practice after an absence of five years or more while 57.3% did not favor the

Table 6.31

Means, Standard Deviation and T-Values of Items from Service Ideal Scales, Occupational and Physical Therapists (N = 130)

Items	Occupational Therapists $\overline{X}$	Occupational Therapists SD	Physical Therapists $\overline{X}$	Physical Therapists SD	T-Value
Factor 5					
30. To what extent do you agree that the lack of training of occupational/physical therapists in dealing with government and other professions account for some of the problems in the profession?	4.565	1.410	4.971	1.146	-1.81
31. To what extent do you agree that the fact that the majority of people in the profession are women account for some of the problems in the profession?	4.113	1.631	4.382	1.657	-0.93
Factor 6					
22. Occupational/physical therapists should be made more accountable for the treatment activities of their patients.	4.932	.998	4.908	1.221	0.12
Factor 7					
12. There should be a re-examination and relicensing for any occupational/physical therapist who wishes to re-enter practice after an absence of five years or more.	5.328	1.044	4.985	1.178	1.74

(cont'd...)

Table 6.31 (cont'd)

Items	Occupational Therapists $\bar{X}$	Occupational Therapists SD	Physical Therapists $\bar{X}$	Physical Therapists SD	T-Value
Factor 9					
24. Occupational/physical therapists should be evaluated only by their fellow occupational/physical therapists.	3.419	1.645	3.776	1.603	-1.25
25. Because of what I am able to do for society, I would like to continue in my present profession even if I could earn more money at another vocation.	4.048	1.419	4.000	1.639	0.18
Factor 12					
19[a] It should be permissible for an occupational/physical therapist to violate medical protocol if it is in the best interests of the patients.	3.086	1.367	3.031	1.790	0.19

[a] Reflected Item.

Table 6.32

Frequency Distribution of the Occupational Therapists' Response to Service Ideal Scales
(N = 62)

Category	Service Ideal Scales 12 %	 19[a] %	 22 %	 24 %	 25 %	 30 %	 31 %
1 (Strongly Disagree)	1.6	16.1	—	9.7	6.5	4.8	9.7
2	—	14.5	—	29.0	9.7	6.5	11.3
3	6.5	24.2	9.7	19.4	14.5	8.1	9.7
4	6.5	25.8	21.0	8.1	25.8	17.7	21.0
5	25.8	9.7	30.6	19.4	29.0	33.9	24.2
6 (Strongly Agree)	58.1	3.2	33.9	14.5	14.5	29.0	24.2
Missing Values	1.6	6.5	4.8	—	—	—	—

Table 6.33

Frequency Distribution of the Physical Therapists' Response to Service Ideal Scales
(N = 68)

Category	Service Ideal Scales 12 %	 19[a] %	 22 %	 24 %	 25 %	 30 %	 31 %
1 (Strongly Disagree)	—	26.5	4.4	7.4	8.8	—	10.3
2	4.4	17.6	—	19.1	14.7	2.9	5.9
3	5.9	13.2	4.4	17.6	11.8	11.8	10.3
4	25.0	13.2	17.6	17.6	20.6	13.2	16.2
5	16.2	10.3	33.8	17.6	20.6	29.4	23.5
6 (Strongly Agree)	48.5	13.2	35.3	19.1	23.5	42.6	33.8
Missing Values	--	5.9	4.4	1.5	—	—	—

[a] Reflected Item

notion that it should be made permissible for any of them to violate medical protocol even if it was in the interest of the patients.

Intercorrelation Among Service Ideal Scale Items

The Pearson correlations computed for the items separately revealed generally low relationships (Tables 6.34 and 6.35). For the occupational therapists, correlations ranged from $\underline{r} = -.011$ to $\underline{r} = .564$, $\underline{P} \leq .001$ and for the physical therapists from $\underline{r} = .004$, to $\underline{r} = -.252$, $\underline{P} \leq .05$.

The highest correlation for occupational therapists $\underline{r} = .564$ existed between their agreement with the lack of training in dealing with government and other professions as accounting for some of the problems in the profession and the extent to which they agreed that the majority of the people in the profession being women accounted for some other problems. The little or no correlation of $\underline{r} = -.011$ existed between the therapists' extent of agreement with the issue of re-examination and relicensing for any therapist who wished to re-enter practice after an absence of five years or more and the extent of their agreement with the notion that because of what they were able to do for the society, they would continue in their profession even if they could earn more money at another vocation.

For the physical therapists, their highest negative correlation ($\underline{r} = -.252$, $\underline{P} \leq .05$) existed between issues of

Table 6.34

Intercorrelation Matrix of Items on the Service Ideal Scales
Occupational Therapists (N = 62)

	Items													
	12		19^a		22		24		25		30		31	
Item No.	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2
12			-.024		.136		.195		-.011		.048		.050	
19^a					-.045		-.063		-.096		.058		-.095	
22							.163		-.129		.018		-.050	
24									.202		.158		.196	
25											.166		-.031	
30													$.564^{***}$	.318
31														

[a] Reflected Item.

*** $\underline{P} \leq .001$.

Table 6.35

Intercorrelation Matrix of Items on the Service Ideal Scales
Physical Therapists (N = 68)

	Items													
	12		19[a]		22		24		25		30		31	
Item No.	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2	r	r^2
12			-.007		.004		-.252*	.064	-.008		.221*	.049	.141	
19[a]					.113		-.176		-.058		.014		.089	
22							-.084		-.171		.061		-.118	
24									.131		.011		.025	
25											-.143		-.099	
30													.242*	.059
31														

[a] Reflected Item.

** $P \leq .05$.

re-examination and relicensing for any therapist who wished to re-enter practice after an absence of five years or more and the evaluation of the physical therapists by their fellow therapists.

The low correlation of r = .004 existed between therapists' extent of agreement with the issue of re-examination and relicensing for any therapist who wished to re-enter practice after an absence of five years or more and their agreement with the accountability demanded for the treatment activities of their patients.

When the data were combined, the correlations ranged from r = -.007 to r = .415, $P \leq .001$ (Table 6.36). The relatively high correlation of r = .415 existed between the items dealing with the extent of agreement to which the therapists acknowledged that the lack of training in dealing with government and other professions and the extent to which they agreed that the majority of the people in the professions being women accounted for some of their problems.

The very low correlation of r - -.007 was found to exist between re-examination and relicensing for therapists who wished to re-enter practice after an absence of five years or more and their sense of commitment to the professions whereby they would like to continue in such professions even if they could earn more money at another vocation.

Table 6.36

Combined Intercorrelations Matrix of Items on the Service Ideal Scale
Occupational and Physical Therapists
(N = 130)

	Items						
	12 r	19[a] r	22 r	24 r	25 r	30 r	31 r
12. There should be a re-examination and relicensing for any occupational/physical therapist who wishes to re-enter practice after an absence of five years or more.		.017	.059	-.065	-.007	.108	.088
19[a]. It should be permissible for an occupational/physical therapist to violate medical protocol if it is in the best interests of the patients.			-.056	.124	.073	-.035	-.014
22. Occupational/physical therapists should be made more accountable for the treatment activities of their patients.				.301	-.154	.037	-.090
24. Occupational/physical therapists should be evaluated only by their fellow occupational/physical therapists.					.158*	.105	.115
25. Because of what I am able to do for society, I would like to continue in my present profession even if I could earn more money at another vocation.						.007	-.070
30. To what extent do you agree that the lack of training of occupational/physical therapists in dealing with government and other professions account for some of the problems in the profession?							.415***

Table 6.36 (cont'd)

31.	To what extent do you agree that the fact that the majority of people in the profession are women accounts for some of the problems in the profession?

[a] Reflected item.

* $P \leq .05$
*** $P \leq .001$

Validity

In applying the criterion that only factor loadings of .35 or greater were acceptable, this study found the items distributing on five dimensions (Factors 5, 6, 7, 9 and 12) (Table 6.37). A closer examination of these items showed that they all seemed to relate to the dimension of service ideal originally conceived in Chapter III.

The items on these factors also appeared to measure service ideal dimension according to the theories of Pavalko (1971) and Goode in Etzioni (1969).

Analysis of Combined Scales

To assess the construct validity of the scales' items, a combined varimax rotated analysis involving sections B and C of the questionnaire was utilized. The result of the analysis revealed that the items loaded on sixteen factors.

When these factors were delineated under the different scales accounted for in this study, the picture in Table 6.38 emerged.

The job satisfaction and job dissatisfaction inventories had nine and six items respectively instead of seven and five accounted for in individual analysis. Professional role autonomy scales received six items instead of seven.

Among the thirteen items purporting to measure professional knowledge scales in the individual analysis, seven

Table 6.37

Factor Analysis (Varimax Rotated) of Service Ideal Scales
Occupational and Physical Therapists (N = 130)

Items	Factor Loading*				
	5	6	7	9	12
12. There should be a re-examination and relicensing for any occupational/physical therapist who wishes to re-enter practice after an absence of five years or more.			.898		
19[a] It should be permissible for an occupational/physical therapist to violate medical protocol if it is in the best interests of the patients.					-.534
22. Occupational/physical therapists should be made more accountable for the treatment activities of their patients.		.812			
24. Occupational/physical therapists should be evaluated only by their fellow occupational/physical therapists.				.542	
25. Because of what I am able to do for society, I would like to continue in my present profession even if I would earn more money at another vocation.				.388	
30. To what extent do you agree that the lack of training of occupational/physical therapists in dealing with government and other professions account for some of the problems in the profession?	.665				

(cont'd...)

Table 6.37 (cont'd)

Items	Factor Loading*				
	5	6	7	9	12
31. To what extent do you agree that the fact that the majority of people in the profession are women account for some of the problems in the profession?	.802				
Eigen Values	1.32007	1.10363	1.04378	.86717	.54942
Percentage of Values	7.9	6.6	6.3	5.2	3.3

[a] Reflected Item.

* All items loaded ≥ .388.

Table 6.38

Factor Analysis (Varimax Rotated) of the Combined Scales
(N = 130)

Item No.	Job Satisfaction	Job Dissatisfaction	Role Autonomy	Knowledge	Service Ideal
11	.365**				
14	.729**				
15	.629**				
16	.741**				
12	.864**				
13	.802**				
21	.426**				
20	.538**				
31	.375**				
8		.472**			
9		.570**			
10		.734**			
38		.446**			
17		.772**			
18		.390**			
26			.495**		
27			.447**		
28			.735**		
29			.703**		
24			.871**		
25			.828**		
49				.712**	
50				.684**	
23				.474**	
36				.378**	
44[a]				-.675**	
32				.553**	
37				.607**	
39				.670**	
42					.447**
43					.741**
51					.717**
52					.776**
33					.868**
46					.690**
30					.383**

[a] Reflected Item

** Loading ≥ .35

were only accounted for out of eight in the combined analysis.

The service ideal scales received seven items in the combined analysis out of which five were accounted for in the individual analysis.

Summary

In examining the concepts of job satisfaction, job dissatisfaction, professional role autonomy, professional knowledge and service ideal, the researcher found that not all the items used in the original questionnaire were useful for data analysis. As a result of the empirical findings, these items were delimited to the ones accounted for under each of the scales in this chapter.

In conclusion, the five scales used in this study were found to exhibit a degree of validity deemed sufficient to test the hypotheses.

CHAPTER VII

CONCEPTUALIZATION OF FURTHER RESEARCH HYPOTHESES

CHAPTER VII

CONCEPTUALIZATION OF FURTHER RESEARCH HYPOTHESES

Given the results of the factor analyses which revealed the multidimensional nature of the scales used in this study, the earlier hypotheses were expanded to explore whether there would be significant differences in the opinions of occupational and physical therapists toward job satisfaction, job dissatisfaction, professional knowledge and service ideal scales. For easy reference, the subscripts denote these new hypotheses.

RH_1 There will be a preference for role autonomy (i.e, in areas of practice, control and organization) by registered occupational therapists in Alberta.

RH_2 There will be a preference for role autonomy (i.e., in areas of practice, control and organization) by registered physical therapists in Alberta.

RH_{3a} There will be no significant differences between the opinions of occupational therapists and physical therapists toward role autonomy.

RH_{3b} There will be no significant differences between the opinions of occupational therapists and physical therapists toward job satisfaction.

RH_{3c} There will be no significant differences between the opinions of occupational therapists and physical therapists toward job dissatisfaction.

RH_{3d} There will be no significant differences between the opinions of occupational therapists and physical therapists toward professional knowledge.

RH_{3e} There will be no significant differences between the opinions of occupational therapists and physical therapists toward service ideal.

RH_4 There will be a positive relationship between the orientation of occupational therapists toward role autonomy and their orientation toward professionalism (i.e., knowledge and service ideal).

RH_5 There will be a positive relationship between the orientation of physical therapists toward role autonomy and their orientation toward professionalism (i.e., knowledge and service ideal).

RH_6 Occupational therapists' orientation with respect to role autonomy will be positively related to their orientation toward job dissatisfaction.

RH_7 Physical therapists' orientation with respect to role autonomy will be positively related to their orientation toward job dissatisfaction.

RH_8 Occupational therapists' orientation with respect to role autonomy will be positively related to their orientation toward job satisfaction.

RH_9 Physical therapists' orientation with respect to role autonomy will be positively related to their orientation toward job satisfaction.

PART III

RESULTS: ROLE AUTONOMY AND OTHER VARIABLES

CHAPTER VIII

ANALYSIS OF RESEARCH HYPOTHESES

CHAPTER VIII

ANALYSIS OF RESEARCH HYPOTHESES

Questionnaires were considered acceptable only if the respondents indicated that they were presently working. A consequence of using this criterion resulted in the use of 130 out of 140 questionnaires for the data analysis (that is, a 4% loss of respondents).

To test the hypotheses, SPSS subprograms PEARSON CORR., T-Test and Descriptive Statistics were utilized. This chapter therefore presents the results of these analyses.

O.T. Role Autonomy

RO_1 The research objective was to determine the degree to which occupational therapists would prefer role autonomy.

RH_1 The accompanying hypothesis stated that there would be a preference for role autonomy (i.e., in areas of practice, control and organization) by registered occupational therapists in Alberta.

The observed results supported this expectation (Tables 8.1 and 8.2). Mean scores range from 4.07 to 5.53. The occupational therapists (96.8%) expressed their varying degrees of agreement with the responsibility to develop both

Table 8.1

Mean, Standard Deviation, Mode and Median of Items
From Professional Role Autonomy Scales
Occupational Therapists (N = 62)

Items	Mean	Standard Deviation	Mode	Median
Factor 1				
1. Occupational therapists should be permitted to terminate or continue treatment of their patients as they deem fit.	5.177	.859	5.00	5.259
6. Occupational therapists as members of a health care team should be allowed to function more independently.	4.983	1.025	6.00	5.125
7. Occupational therapists within medical settings should be allowed to provide their services to clients in need of those services without the requirement of a physician's referral or prescription.	4.065	1.535	5.00	4.423
8. Occupational therapists should be allowed to make their own decisions regarding problems that come up with the treatment of their patients.	4.803	1.166	6.00	5.000
Factor 2				
3. Occupational therapists should be responsible for developing the budget for occupational therapy departments in their facilities.	5.393	.802	6.00	5.629
4. Occupational therapists should be responsible for developing staff projections for the occupational therapy departments in their facilities.	5.525	.744	6.00	5.737

Table 8.2

Frequency Distribution of the Occupational Therapists' Responses to the Professional Role Autonomy Scales (N = 62)

	Autonomy Scale Items					
Category	1 %	3 %	4 %	6 %	7 %	8 %
1 Strongly Disagree	--	--	--	--	6.5	--
2	1.6	--	--	3.2	16.1	4.8
3	3.2	1.6	1.6	3.2	8.1	9.7
4	9.7	14.5	9.7	21.0	21.0	19.4
5	46.8	25.8	22.6	32.3	30.6	30.6
6 (Strongly Agree)	38.7	56.5	64.5	35.5	17.7	33.9
Missing Values	--	1.6	1.6	4.8	--	1.6

the budget and staff projections in their departments.

Ninety-five percent felt that they should be permitted to terminate and continue the treatment of their patients as they deemed fit. Eighty-eight percent recognized the need to function more independently as members of a health care team. Eighty-four percent supported the view that occupational therapists be allowed to make their own decisions regarding problems that come up with the treatment of their patients.

On the important issue of being allowed to provide their services to clients in need of those services without the requirement of a physician's referral or prescription, 69.3% agreed. A closer investigation revealed that out of this percentage, 17.7% strongly agreed and of the 30.7% that disagreed, 6.5% expressed strong disagreement.

Thus, it can be inferred from the results of the role autonomy items that occupational therapists in Alberta generally accepted the fact that they needed more autonomy particularly in areas of practice, control and organization of their profession.

P.T. Role Autonomy

RO_2 The second research objective was to determine the degree to which physical therapists would prefer role autonomy.

RH_2 The research hypothesis derived from the above was that there would be a preference for role autonomy (i.e., in areas of practice, control and organization) by registered physical therapists in Alberta.

Tables 8.3 and 8.4 revealed that physical therapists generally agreed with the items on the role autonomy scale except one. The highest percentage (95.5%) was recorded on the issue of being permitted to terminate or continue treatment of their patients as they deemed fit. Eighty eight point two percent favored the views that physical therapists should be responsible for the development of budget and also staff projections in their facilities.

Eighty-eight point three percent agreed that physical therapists as members of a health care team should be allowed to function more independently, while 80.9% accepted the view that physical therapists be allowed to make their own decisions regarding problems that come up with the treatment of their patients.

However, it is interesting to note that while the physical therapists substantially agreed with the above views, particularly items that dealt with the termination and continuation of treatment as they deemed fit and also being allowed to make their own decisions regarding problems that came up with their patients' treatment, they did not feel they should have the responsibility to provide services to clients in need of those services without the requirement of a physician's referral or prescription.

Of those sampled, 60.3% disagreed while 39.7% agreed. A closer examination revealed that 16.2% of those that disagreed felt rather strongly while 13.2% of those that agreed felt strongly about the opinion.

Table 8.3

Mean, Standard Deviation, Mode and Median of Items
From Professional Role Autonomy Scales
Physical Therapists (N = 68)

Items	Mean	Standard Deviation	Mode	Median
Factor 1				
1. Physical therapists should be allowed to terminate or continue treatment of their patients as they deem fit.	5.418	.907	6.00	5.721
6. Physical therapists as members of a health care team should be allowed to function more independently.	4.761	1.143	5.00	4.926
7. Physical therapists within medical settings should be allowed to provide their services to clients in need of those services without the requirements of a physicians's referral or prescription.	3.309	1.595	3.00	3.150
8. Physical therapists should be allowed to make their own decisions regarding problems that come up with the treatment of their patients.	4.567	1.270	5.00	4.783
Factor 2				
3. Physical therapists should be responsible for developing the budget for physical therapy departments in their facilities.	5.030	1.215	6.00	4.382
4. Physical therapists should be responsible for developing staff projections for the physical therapy departments in their facilities.	5.182	1.149	6.00	5.529

Table 8.4

Frequency Distribution of the Physical Therapists' Responses to the Professional Role Autonomy Scales
(N = 68)

Category	Autonomy Scale Items 1 %	 3 %	 4 %	 6 %	 7 %	 8 %
1 Strongly Disagree	--	2.9	2.9	2.9	16.2	2.9
2	1.5	1.5	--	1.5	14.7	4.4
3	1.5	4.4	5.9	5.9	29.4	10.3
4	14.7	17.6	8.8	22.1	14.7	22.1
5	17.6	25.0	29.4	39.7	11.8	33.8
6 Strongly Disagree	63.2	45.6	50.0	26.5	13.2	25.0
Missing Values	1.5	2.9	2.9	1.5	--	1.5

It can therefore be inferred that the hypothesis has been supported in part.

Comparison of O.T. and P.T. Role Autonomy

RO_3 The third research objective was to determine the degree to which both the occupational and physical therapists have similar opinions regarding the role autonomy.

RH_{3a} The derived hypothesis stated that there would be no significant differences between the opinions of occupational and physical therapists toward role autonomy.

It was established from the findings in Tables 8.1, 8.2, 8.3 and 8.4 that while occupational therapists generally agreed with the opinions expressed in all items on the role autonomy scales, the physical therapists on the other hand agreed generally with all but one item.

As mentioned in Chapter VI, these items formed two scales. When the t-test was applied to the individual scales (Table 8.5), scale two showed a significant difference in the opinions of occupational therapists toward more preference. The t-test analysis of the responses to the combined role autonomy scales indicated that the hypothesis was not supported ($\underline{t} = 2.23$, $\underline{P} \leq .05$) (Table 8.6).

The results of this analysis showed that occupational therapists preferred role autonomy more than the physical therapists.

Table 8.5

T-Test Analysis of Occupational and Physical Therapists' Responses to the Individual Role Autonomy Scales
(N = 130)

Scales	Groups	N. of Cases	Mean	Pooled Variance Estimate			Separate Variance Estimate		
				T-Value	DF	2-tail P	T-Value	DF	2-tail P
1	OTs	62	4.75	1.57	128	.118	---	---	---
	PTs	68	4.51						
2	OTs	62	5.45						
	PTs	68	5.11				2.11	114.08	.037*

Table 8.6

T-Test Analysis of Occupational and Physical Therapists' Responses to the Combined Scales on Role Autonomy
(N = 130)

Groups	N. of Cases	Mean	Pooled Variance Estimate			Separate Variance Estimate		
			T-Value	DF	2-tail P	T-Value	DF	2-tail P
OTs	62	4.99	2.23	128	.027*	---	---	---
PTs	68	4.70						

* $P \leq .05$.

Comparison of O.T. and P.T. Job Satisfaction

RH_{3b} The second hypothesis derived from the third research objective stated that there would be no significant differences between the opinions of occupational and physical therapists toward job satisfaction scales.

T-Test analysis of the responses to the individual job satisfaction scales revealed no significant differences in their opinions (Table 8.7). The t-test analysis of the responses to the combined scales also indicated no significant differences in their opinions (Table 8.8).

As a result of this finding, the hypothesis was therefore supported.

Comparison of O.T.s and P.T.s Job Dissatisfaction

RH_{3c} The third hypothesis derived from the third research objective indicated that there would be no significant differences between the opinions of occupational and physical therapists toward job dissatisfaction scales.

The findings from the t-tests to the responses on the scale revealed no existence of significant differences in their opinions (Table 8.9). It appeared that both groups shared the same degree of satisfaction with the scale items.

Table 8.7

T-Test Analysis of Occupational and Physical Therapists' Responses to the Individual Scales of Job Satisfaction
(N = 130)

Scales	Groups	N. of Cases	Mean	Pooled Variance Estimate T-Value	DF	2-tail P
1	OTs	62	4.69	1.00	128	.318
	PTs	68	4.52			
2	OTs	62	4.56	-1.29	128	.200
	PTs	68	4.73			

Table 8.8

T-Test Analysis of Occupational and Physical Therapists' Responses to Combined Job Satisfaction Scales
(N = 130)

Groups	N. of Cases	Mean	Pooled Variance Estimate T-Value	DF	2-tail P
OTs	62	4.66	.56	128	0.575
PTs	68	4.59			

Table 8.9

T-Test Analysis of Occupational and Physical Therapists' Responses to Job Dissatisfaction Scale
(N = 130)

Groups	No. of Cases	Mean	Pooled Variance Estimate T-Value	 DF	 2-tail P
OTs	62	3.80			
PTs	68	4.00	-1.17	128	0.246

Comparison of O.T.s and P.T.s Professional Knowledge

RH_{3d} The fourth hypothesis from the third research objective stated that there would be no significant differences between the opinions of occupational and physical therapists toward professional knowledge scales.

Table 8.10 showed t-test analysis of both groups' responses to the individual scales of Professional Knowledge. The findings indicated that occupational therapists differed significantly in their opinions on scale one ($t = 2.02$, $P \leq .04$) and scale three ($t = 2.34$, $P \leq .02$). When the t-test was applied to the combined scales, (Table 8.11), the findings still revealed a significant difference in their opinions ($t = 2.54$, $P \leq .012$).

The hypothesis was therefore not supported. One can infer that occupational therapists were more oriented toward a higher level of professional knowledge than the physical therapists.

Comparison of O.T.s and P.T.s Service Ideal

RH_{3e} The fifth hypothesis derived from the third objective stated that there would be no significant differences between the opinions of occupational and physical therapists toward service ideal scales.

The t-test analysis of the responses to both the individual and combined scales revealed that there were no significant differences in the opinions of occupational and physical therapists (Tables 8.12 and 8.13).

Table 8.10

T-test Analysis of Occupational and Physical Therapists'
Responses to the Individual Scales of Professional Knowledge
(N = 130)

Scales	Groups	N. of Cases	Mean	Pooled Variance Estimate T-Value	Pooled Variance Estimate DF	Pooled Variance Estimate 2-tail P	Separate Variance Estimate T-Value	Separate Variance Estimate DF	Separate Variance Estimate 2-tail P
1	OTs	62	3.87				2.02	114.98	0.046*
	PTs	68	3.60						
2	OTs	62	4.90	0.22	128	0.826			
	PTs	68	4.88						
3	OTs	62	4.70	2.34	128	0.021*			
	PTs	68	4.18						
4	OTs	60	3.82	0.42	125	0.673			
	PTs	67	3.69						
5	OTs	61	1.84	-0.79	127	0.429			
	PTs	68	2.01						

* $P \leq .05$.

Table 8.11

T-Test Analysis of Occupational and Physical Therapists' Responses to Combined Scales of Professional Knowledge (N = 130)

Groups	N of Cases	Mean	Pooled Variance Estimate T-Value	DF	2-tail P
OTs	62	4.19			
PTs	68	4.00	2.54	128	0.012*

* $\underline{P} \leq .05$.

Table 8.12

T-Test Analysis of Occupational and Physical Therapists' Responses to the Individual Scales of Service Ideal
(N = 130)

				Pooled Variance Estimate			Separate Variance Estimate		
Scales	Groups	N of Cases	Mean	T-Value	DF	2-tail P	T-Value	DF	2-tail P
1	OTs	62	4.34	-1.56	128	0.120			
	PTs	68	4.68						
2	OTs	59	4.93	0.12	122	0.903			
	PTs	65	4.91						
3	OTs	61	5.33	1.74	127	0.084			
	PTs	68	4.99						
4	OTs	62	3.73	-0.80	128	0.425			
	PTs	68	3.90						
5	OTs	58	3.91						
	PTs	64	3.97				-0.19	116.74	0.848

Table 8.13

T-Test Analysis of Occupational and Physical Therapists' Responses to Combined Scales of Service Ideal
(N = 130)

Groups	N of Cases	Mean	Pooled Variance Estimate		
			T-Value	DF	2-tail *P*
OTs	62	4.32	-0.99	128	0.323
PTs	68	4.43			

As a result the hypothesis was supported. It appeared that their opinions toward the scale items are similar.

O.T. Professionalism and Role Autonomy

RO_4 The fourth objective was to determine the nature of relationship, if any, between the degree of orientation the occupational therapists have toward professionalism and their degree of orientation toward role autonomy.

RH_4 The derived hypothesis stated that there would be a positive relationship between the orientation of occupational therapists toward role autonomy and their orientation toward professionalism (i.e., knowledge and service ideal).

Table 8.14 revealed the direction of observed relationships to each of the individual scales of knowledge and service ideal. A close examination showed that scales 4 and 5 on knowledge and 4 and 5 on service ideal dimensions in relation to role autonomy scale 1 did not support the hypothesized relationships. Also knowledge scale 5 and service ideal scales 1 and 5 in relation to role autonomy scale 2 did not support the hypothesized relationships.

When all the scales were combined (Table 8.15), the observed relationships supported the hypothesized.

The data in Table 8.16 indicated the correlations with individual scales were generally low. They ranged from $\underline{r} = .000$, $\underline{P} \leq 49$ to $\underline{r} = .388$, $\underline{P} \leq .01$.

The data in Table 8.17 showed the combined correlations between the autonomy scales and the professionalism

Table 8.14

Hypothesized (H), Observed (O) and Significance (P) of Individual Role Autonomy Scales and Occupational Therapists' Orientation Toward Individual Professionalism Scales (N = 62)

Autonomy Scales	Professionalism Scales							
	Knowledge				Service Ideal			
		H	O	P		H	O	P
1	1	+	+	NS	1	+	+	**
	2	+	+	NS	2	+	+	NS
	3	+	+	**	3	+	+	NS
	4	+	−	NS	4	+	−	NS
	5	+	−	NS	5	+	−	*
2	1	+	+	NS	1	+	−	NS
	2	+	+	NS	2	+	+	**
	3	+	+	*	3	+	+	**
	4	+	+	NS	4	+	+	*
	5	+	−	NS	5	+	−	NS

+,- Direction of Relationships.
* P ≤ .05.
** P ≤ .01.
NS Non Significant.

Table 8.15

Hypothesized (H), Observed (O) and Significance (P) of Combined Role Autonomy Scales and Occupational Therapists' Orientation Toward Combined Professionalism Scales
(N = 62)

	Professionalism Scales					
	Knowledge			Service Ideal		
	H	O	P	H	O	P
Autonomy Scales	+	+	*	+	+	NS

+ Direction of Relationships.
* P ≤ .05.
NS Non Significant.

Table 8.16

Correlations Between the Individual Role Autonomy Scales and Occupational Therapists' Orientation Toward the Individual Scales of Professionalism
(N = 62)

Autonomy Scales		Professionalism Scales									
		Knowledge					Service Ideal				
		1	2	3	4	5	1	2	3	4	5
1.	r =	.066	.182	.388**	-.017	-.178	.313**	.177	.079	-.115	-.254*
	r² =	--	--	.151	--	--	.098	--	--	--	.065
2.	r =	.062	.059	.257*	.144	-.076	.000	.374**	.323**	.234*	-.158
	r² =	--	--	.066	--	--	--	.140	.104	.055	--

Table 8.17

Combined Correlations Between Role Autonomy Scales and Occupational Therapists' Orientation Toward Professionalism Scales
(N = 62)

		Professionalism Scales	
		Knowledge	Service Ideal
Autonomy Scales	r =	.290*	.197
	r² =	.084	.039

* $\underline{p} \leq .05$.
** $\underline{p} \leq .01$.

scales. The table gave an indication that occupational therapists' orientation toward role autonomy was positively and significantly correlated with knowledge ($\underline{r} = .290$, $\underline{P} \leq .05$), but rather weakly correlated with service ideal ($\underline{r} = .197$, $\underline{P} \leq .06$). Although the correlation with knowledge was statistically significant, the r^2 indicated that the variables had a small amount of common variance.

The inference from these findings seemed to indicate that occupational therapists attached a higher degree of importance to professional knowledge than the ideal of service.

P.T. Professionalism and Role Autonomy

RO_5 The research objective was to determine the nature of relationship, if any, between the degree of orientation the physical therapists have toward professionalism (i.e., service and knowledge) and their degree of orientation toward role autonomy.

RH_5 The derived hypothesis stated that there would be a positive relationship between the orientation of physical therapists toward role autonomy and their orientation toward professionalism.

Table 8.18 revealed the direction of observed relationships to each of the individual scales of knowledge and service ideal. A close examination showed that knowledge scales 2 and 4 and service ideal scales 3, 4 and 5 in relation to role autonomy scale 1 did not support the

Table 8.18

Hypothesized (H), Observed (O) and Significance (P) of Individual Role Autonomy Scales and Physical Therapists' Orientation Toward Individual Professionalism Scales
(N = 68)

Autonomy Scales	Professionalism Scales							
	Knowledge				Service Ideal			
		H	O	P		H	O	P
1	1	+	+	NS	1	+	+	NS
	2	+	-	NS	2	+	+	NS
	3	+	+	NS	3	+	-	NS
	4	+	-	NS	4	+	-	NS
	5	+	+	NS	5	+	-	*
2	1	+	+	NS	1	+	+	**
	2	+	-	NS	2	+	-	NS
	3	+	+	NS	3	+	+	NS
	4	+	-	NS	4	+	-	NS
	5	+	-	NS	5	+	-	NS

+,-	Direction of Relationships.
*	P ≤ .05.
**	P ≤ .01.
NS	Non Significant.

hypothesized relationships. The data for knowledge scales 2, 4 and 5 and service ideal scales 2, 4 and 5 did not support the hypothesized relationships.

When all the scales were combined (Table 8.19), the observed relationships supported only the knowledge dimension.

The data in Table 8.20 indicated that the correlations with the individual scales were generally low as shown by their variances. These ranged from $\underline{r} = -.005$, $\underline{P} \leq .48$ to $\underline{r} = .366$, $\underline{P} \leq .01$.

The data in Table 8.21 showed the combined correlations between the autonomy scales and the professionalism scales. This indicated that physical therapists' orientation toward role autonomy was weakly but positively correlated with knowledge ($\underline{r} = .038$, $\underline{P} \leq .38$) and negatively correlated with service ideal ($\underline{r} = .011$, $\underline{P} \leq .46$).

The result of the findings seemed to indicate that the physical therapists were not particularly oriented toward a high degree of knowledge and service ideal.

O.T. Role Autonomy and Job Dissatisfaction

RO_6 The research objective was to determine the nature of relationship, if any, between the degree of orientation the occupational therapists have toward role autonomy and their orientation toward job dissatisfaction.

RH_6 The research hypothesis stated that occupational therapists' orientation with respect to role autonomy will be positively related to their orientation toward

Table 8.19

Hypothesized (H), Observed (O) and Significance (P) of Combined Role Autonomy Scales and Physical Therapists' Orientation Toward Combined Professionalism Scales

	Professionalism Scales					
	Knowledge			Service Ideal		
	H	O	P	H	O	P
Autonomy Scales	+	+	NS	+	-	NS

+,- Direction of Relationships.
NS Non Significant.

Table 8.20

Correlations Between the Individual Role Autonomy Scales and Physical Therapists' Orientation Toward the Individual Scales of Professionalism
(N = 68)

Autonomy Scales		Professionalism Scales									
		Knowledge					Service Ideal				
		1	2	3	4	5	1	2	3	4	5
1.	r =	.132	-.007	.036	-.065	.018	.054	.183	-.161	-.006	-.285*
	r^2 =	--	--	--	--	--	--	--	--	--	.081
2.	r =	.123	-.198	.120	-.005	-.093	.366**	-.060	.138	-.090	-.087
	r^2 =	--	--	--	--	--	.134	--	--	--	--

Table 8.21

Combined Correlations Between Role Autonomy Scales and Physical Therapists' Orientation Toward Professionalism Scales
(N = 68)

		Professionalism Scales	
		Knowledge	Service Ideal
Autonomy Scales	r =	.038	-.011
	r^2 =	.146	--

* $\underline{P} \leq .05$.
** $\underline{P} \leq .01$.

job dissatisfaction.

Table 8.22 showed the direction of observed relationships between the individual role autonomy scales and job dissatisfaction scale. The observed relationship to role autonomy scale 1 did not concur with the hypothesized.

When the scales were combined (Table 8.23), the observed relationship tallied with the hypothesized.

The table 8.24 revealed a weak negative correlation ($r = -.061$, $P \leq .32$) with role autonomy scale 1 and weak positive correlation ($r = .116$, $P \leq .18$) with role autonomy scale 2. When the combined correlation was done between the role autonomy scales and job dissatisfaction scale, a very weak positive correlation ($r = .001$, $P \leq .49$) was found (Table 8.25).

Thus, the predicted positive relationship between occupational therapists' orientations to role autonomy and to job dissatisfaction was supported. The inference from this finding seemed to indicate that there was very little relationship between their feelings toward job dissatisfaction and their feelings toward role autonomy.

P.T.s Role Autonomy and Job Dissatisfaction

RO$_7$ The seventh research objective was to determine the nature of relationship, if any, between the degree of orientation the physical therapists have toward role autonomy and their orientation toward job dissatisfaction.

Table 8.22

Hypothesized (H), Observed (O) and Significance (P) of Individual Role Autonomy Scales and Occupational Therapists' Orientation Toward Job Dissatisfaction Scale
(N = 62)

Autonomy Scales	Job Dissatisfaction Scale		
	H	O	P
1	+	-	NS
2	+	+	NS

Table 8.23

Hypothesized (H), Observed (O) and Significance (P) of Combined Role Autonomy Scales and Occupational Therapists' Orientation Toward Job Dissatisfaction Scale
(N = 62)

	Job Dissatisfaction Scale		
	H	O	P
Autonomy Scales	+	+	NS

+,- Direction of Relationship.
NS Non Significant.

Table 8.24

Correlations Between the Individual Role Autonomy Scales and Occupational Therapists' Orientation Toward Job Dissatisfaction Scale (N = 62)

Autonomy Scales	Job Dissatisfaction Scale
1	r = -.061 r^2 = --
2	r = .116 r^2 = .013

Table 8.25

Combined Correlation Between Role Autonomy Scales and Occupational Therapists' Orientation Toward Job Dissatisfaction Scale (N = 62)

	Job Dissatisfaction Scale	
Autonomy Scales	r = .001	r^2 = .012

RH_7 The derived research hypothesis stated that physical therapists' orientation with respect to role autonomy would be positively related to their orientation toward job dissatisfaction.

The direction of the observed relationships to the individual and the combined scales did not support the hypothesized relationships (Tables 8.26 and 8.27).

The data in Table 8.28 revealed negative correlations ($\underline{r} = -.253$, $\underline{P} \leq .05$ and $\underline{r} = -.051$, $\underline{P} \leq .34$) to role autonomy scales 1, and 2 respectively.

The data in Table 8.29 showed a combined correlation between the role autonomy and job dissatisfaction scales. It was found that $\underline{r} = -.226$, $\underline{P} \leq .05$. Although statistically significant, the r^2 indicated that the variables had a small amount of variance.

The result of this finding was the rejection of the hypothesis. This seemed to indicate that their feeling of dissatisfaction had nothing to do with their desire for role autonomy.

O.T. Role Autonomy and Job Satisfaction

RO_8 The research objective was to determine the nature of relationship, if any, between the degree of orientation the occupational therapists have toward role autonomy and their orientation toward job satisfaction.

RH_8 The hypothesis derived from this objective expected that occupational therapists' orientation with respect

Table 8.26

Hypothesized (H), Observed (O) and Significance (P) of Individual Role Autonomy Scales and Physical Therapists' Orientation Toward Job Dissatisfaction Scale
(N = 68)

Autonomy Scales	Job Dissatisfaction Scale		
	H	O	P
1	+	-	*
2	+	-	NS

Table 8.27

Hypothesized (H), Observed (O) and Significance (P) of Combined Role Autonomy Scales and Physical Therapists' Orientation Toward Job Dissatisfaction Scale
(N = 68)

Autonomy Scales	Job Dissatisfaction Scale		
	H	O	P
	+	-	NS

+,- Direction of Relationship.
* $P \leq .05$.
NS Non Significant.

Table 8.28

Correlations Between the Individual Role Autonomy Scales and Physical Therapists' Orientation Toward Job Dissatisfaction Scale

(N = 68)

Autonomy Scales	Job Dissatisfaction Scale
1	$r = -.253$* $r^2 = .064$
2	$r = -.051$ $r^2 =$ --

Table 8.29

Combined Correlation Between Role Autonomy Scales and Physical Therapists' Orientation Toward Job Dissatisfaction Scale

(N = 68)

	Job Dissatisfaction Scale	
Autonomy Scales	$r = -.226$*	$r^2 = .051$

* $\underline{P} \leq .05$.

to role autonomy would be positively related to their orientation toward job satisfaction.

Table 8.30 revealed the direction of observed relationships to each of the individual scales of job satisfaction. A close examination showed that only role autonomy scale 1 did not support the hypothesized relationship with job satisfaction scale 1.

When the scales were combined (Table 8.31), the observed supported the hypothesized relationship.

Table 8.32 revealed the intercorrelations between the scales. It was found that role autonomy scale 2 showed statistically significant relationships ($\underline{r} = .212$, $\underline{P} \leq .05$ and $\underline{r} = .263$, $\underline{P} \leq .05$) with job satisfaction scales 1 and 2, even though the variances are small as revealed by their r^2.

Table 8.33 gave the combined correlation between the role autonomy scales and job satisfaction scales. The result was that $\underline{r} = .11$, $\underline{P} \leq .20$.

From the latter result, it appeared that occupational therapists' orientation toward job satisfaction had little relationship with their orientation toward role autonomy.

P.T. Role Autonomy and Job Satisfaction

RO_9 The ninth research objective was to determine the nature of relationship, if any, between the degree of orientation the physical therapists have toward role autonomy and their orientation toward job satisfaction.

Table 8.30

Hypothesized (H), Observed (O) and Significance (P) of
Individual Role Autonomy Scales and Occupational Therapists'
Oriented Toward Individual Job Satisfaction Scales
(N = 62)

Autonomy Scales	Job Satisfaction Scales					
	1			2		
	H	O	P	H	O	P
1	+	-	NS	+	+	NS
2	+	+	*	+	+	*

Table 8.31

Hypothesized (H), Observed (O) and Significance (P) of
Combined Role Autonomy Scales and Occupational Therapists'
Orientation Toward Job Satisfaction Scales
(N = 62)

Autonomy Scales	Job Satisfaction Scales		
	H	O	P
	+	+	NS

+,- Direction of Relationship.
* $P \leq .05$.
NS Non Significant.

Table 8.32

Correlations Between the Individual Role Autonomy Scales and Occupational Therapists' Orientation Toward the Individual Scales of Job Satisfaction
(N = 62)

Autonomy Scales		Job Satisfaction Scales	
		1	2
1	$r =$	-.023	.059
	$r^2 =$	--	--
2	$r =$	.212*	.263*
	$r^2 =$	.045	.069

Table 8.33

Combined Correlation Between Role Autonomy Scales and Occupational Therapists' Orientation Toward Combined Job Satisfaction Scales
(N = 62)

	Job Satisfaction Scales	
Autonomy Scales	$r = .11$	$r^2 =$ --

RH_9 The research hypothesis derived from the above objective predicted that physical therapists' orientation with respect to role autonomy would be positively related to their orientation toward job satisfaction.

An examination of Table 8.34 showed that role autonomy scales 1 and 2 did not support the hypothesized relationship with job satisfaction scale 1. When the scales were combined in Table 8.35, the observed did not support the hypothesized relationship.

Table 8.36 revealed the intercorrelations between the scales. Role autonomy scale 1 showed a significant positive correlation ($\underline{r} = .246$, $\underline{P} \leq .05$) with job satisfaction scale 2 while role autonomy scale 2 indicated a significant positive correlation ($\underline{r} = .285$, $\underline{P} \leq .05$) with job satisfaction scale 2.

The combined correlation between these scales revealed a negative correlation ($\underline{r} = -.077$, $\underline{P} \leq .27$) (Table 8.37). From this finding it can be inferred that their feelings to both dimensions are mutually exclusive.

Table 8.34

Hypothesized (H), Observed (O) and Significance ($\underline{P}$) of Individual Role Autonomy Scales and Physical Therapists' Orientation Toward Individual Job Satisfaction Scales (N = 68)

Autonomy Scales	Job Satisfaction Scales					
	1			2		
	H	O	$\underline{P}$	H	O	$\underline{P}$
1	+	-	NS	+	+	*
2	+	-	NS	+	+	*

Table 8.35

Hypothesized (H), Observed (O) and Significance ($\underline{P}$) of Combined Role Autonomy Scales and Physical Therapists' Orientation Toward Combined Job Satisfaction Scales (N = 68)

Autonomy Scales	Job Satisfaction Scales		
	H	O	P
	+	-	NS

+,- Direction of Relationship.
* $\underline{P} \leq .05$.
NS Non Significant.

Table 8.36

Correlations Between the Individual Role Autonomy Scales and Physical Therapists' Orientation Toward the Individual Job Satisfaction Scales
(N = 62)

Autonomy Scales		Job Satisfaction Scales	
		1	2
1	r =	-.151	.246*
	r^2 =	.023	.061
2	r =	-.085	.285*
	r^2 =	--	.081

Table 8.37

Combined Correlation Between Role Autonomy Scales and Physical Therapists' Orientation to Combined Job Satisfaction Scales
(N = 62)

Autonomy Scales	Job Satisfaction Scales	
	r = -.077	r^2 = --

* $\underline{P} \leq .05$.

CHAPTER IX

ANALYSIS OF THE EFFECTS OF BACKGROUND AND OTHER VARIABLES

CHAPTER IX

ANALYSIS OF THE EFFECTS OF BACKGROUND AND OTHER VARIABLES

This chapter discusses the degree to which other variables may have determined the respondents' feelings toward role autonomy and other dimensions. The variables selected for examination were background variables, and the variable that examined how the public evaluated the respondents' social standing. The chapter also discusses other variable items that scored less than .35 of factor loadings considered significant by the SPSS subprogram.

Background Variables

Descriptive statistics, t-tests and one-way analyses of variance (ANOVA) were employed to measure the association of background variables (sex, age, marital status, present position and academic qualifications) with role autonomy, job satisfaction, job dissatisfaction, professional knowledge and service ideal dimensions.

These tests were utilized on the responses of occupational and physical therapists toward each of the individual and the combined scales used in this study.

Occupational Therapists' Responses

Sex

It was interesting to discover that there were no males among the occupational therapy respondents. The females constituted 96.8% with 3.2% no response (see Chapter VII).

Age

The age variable was categorized under two groups--those under 35 years and those over 35 years of age. When the variable was controlled for each of the individual scales, the t-test showed a value of statistical significance on service ideal scale 4 ($t = -2.80$, $\underline{P} \leq .007$) (Table 9.1).

When the scales were combined, the t-test analysis revealed no value of statistical significance.

Marital Status

There were three groups under this category. Group 1--single, Group 2--married and Group 3--widowed, divorced or separated. When one-way analysis of variance (ANOVA) was employed on each of individual scales, a value of statistical significance was revealed (F Ratio = 5.306, $\underline{P} \leq .008$) (Table 9.2) on service ideal scale 4. The Scheffe procedure set at .100 revealed that the married respondents differed significantly between the single and

Table 9.1

T-Test Analysis on Age of Occupational Therapists with Regard to Service Ideal Scale 4
(N = 62)

Scale	Groups	N of Cases	Mean	Pooled Variance Estimate T-Value	DF	2-tail P
4	under 35	44	3.48	-2.80	60	.007**
	over 35	18	4.36			

** P ≤ .01.

Table 9.2

One-Way Analysis of Variance on Marital Status of Occupational Therapists with Regard to Service Ideal Scale 4
(N = 62)

	Groups	Count	Mean	F Ratio	F-Prob.
1.	Single	20	3.075	5.306	.008**
2.	Married	37	4.08		
3.	Widowed/divorced/ separated	5	3.8		

Scheffe Procedure: Group 2 significantly different at .100 level.

** P ≤ .01.

the widowed, etc. in their opinions on this scale.

When the scales were combined, the same test revealed a value of statistical significance again on service ideal scales (F Ratio = 3.639, $\underline{P} \leq .03$) (Table 9.3). The Scheffe procedure again confirmed the married respondents as having significantly different opinions from either the single or the widowed/separated/divorced on this issue.

It seemed, therefore, that the married respondents were more in favor of service ideal for professional growth than either the single or the widowed, etc. Responses to other combined scales of job satisfaction, job dissatisfaction, role autonomy and professional knowledge were not statistically significant.

Present Position

The respondents were grouped into three under this category. Group 1 represented those who were either directors, supervisors, or sole charge therapists; Group 2 were the staff therapists; while Group 3 composed the private practitioners, private consultants and Government consultants.

One-way analysis of variance (ANOVA) was performed on each of the individual scales. Values of statistical significance were found in role autonomy scale 1 (F Ratio = 3.45, $\underline{P} \leq .04$) (Table 9.4) and in role autonomy scale 2 (F Ratio = 3.96, $\underline{P} \leq .03$) (Table 9.5).

The Scheffe procedure employed revealed that Group 3

Table 9.3

One-Way Analysis of Variance on Marital Status of Occupational Therapists with Regard to Combined Servide Ideal Scales
(N = 62)

	Groups	Count	Mean	F Ratio	F Prob.
1.	Single	20	4.016		
2.	Married	37	4.457	3.639	.03*
3.	Widowed/Divorced/ Separated	5	4.543		
Scheffe Procedure: Group 2 significantly different at .100 level					

* $\underline{P} \leq .05$.

Table 9.4

One-Way Analysis of Variance on Positions of Occupational Therapists with Regard to Role Autonomy Scale 1

Groups	Count	Mean	F Ratio	F Prob.
1	15	4.79	3.45	.04*
2	33	4.66		
3	5	5.60		

Scheffe Procedure: Group 3 significantly different at .100 level

Table 9.5

One-Way Analysis of Variance on Positions of Occupational Therapists with Regard to Role Autonomy Scale 2

Groups	Count	Mean	F Ratio	F Prob.
1	15	5.83	3.96	.03*
2	33	5.20		
3	5	5.30		

Scheffe procedure: Group 1 significantly different at .100 level

* $P \leq .05$.

Group 1 = Directors, Supervisors and Sole Charge Therapists.
Group 2 = Staff Therapists.
Group 3 = Private Practitioners, Private and Government Consultants.

(i.e. private practitioners, private and Government consultants) differed significantly in their opinions toward role autonomy scale 1 from either of the other two groups. On role autonomy scale 2, it was interesting to find out that Group 1 (i.e., directors, supervisors and sole charge therapists) differed significantly in their opinions from the other two groups.

When the one-way analysis of variance was utilized on the combined scales, a significant difference in the occupational therapists' opinions was found on role autonomy and professional knowledge dimensions. On role autonomy, F Ratio = 3.343, $\underline{P} \leq .04$ (Table 9.6). The Scheffe procedure set at .100 level found Group 3 (i.e., private practitioners, private and Government consultants) to differ significantly from Groups 1 and 2. The inference therefore is that Group 3 was more inclined than either of the other two to favor a higher degree of autonomy in their professional practices.

On professional knowledge, F Ratio = 2.797; $\underline{P} \leq 0.7$ (Table 9.7). Although this value was not statistically significant, the Scheffe procedure set at .100 revealed that the same Group 3 (i.e., private practitioners, private and Government consultants) differed significantly in their opinions than either Groups 1 or 2. The inference here also is that this group preferred a higher level of professional knowledge than either of the other two groups.

Table 9.6

One-Way Analysis of Variance on Positions of Occupational Therapists with Regard to Combined Role Autonomy Scales

Groups	Count	Mean	F Ratio	F Prob.
1	15	5.153		
2	33	4.837	3.343	.04*
3	5	5.500		

Scheffe procedure: Group 3 significantly different at .100 level

Table 9.7

One-Way Analysis of Variance on Positions of Occupational Therapists with Regard to Combined Professional Knowledge Scales

Groups	Count	Mean	F Ratio	F Prob.
1	15	4.311		
2	33	4.154	2.797	.07
3	5	4.591		

Scheffe procedure: Group 3 significantly different at .100 level

* $P \leq .05$.

Group 1 = Director and Supervisor and Sole Charge Therapists.
Group 2 = Staff Therapists.
Group 3 = Private Practitioner and Private and Government Consultants.

Academic Qualifications

This variable was categorized under two groups. Group 1 was for Diploma holders while Group 2 was for Degree holders. There was no other respondent with a higher academic qualification. The T-test performed on individual scales revealed no value of statistical significance. When the T-test was utilized on combined scales, a value of statistical significance was found on role autonomy scales ($t = -3.66$, $P \leq .001$) (Table 9.8). The inference from these findings seemed to indicate that the Degree holders were very high in their preference for role autonomy than the Diploma holders.

Physical Therapists' Responses

Sex

This variable had two groups--Group 1 for males and Group 2 for females.

On individual scales, T-test revealed a value of statistical significance on professional knowledge scale 1 ($t = -2.09$, $P \leq .04$) (Table 9.9).

When the T-test was applied to the combined scales, a value of statistical significance was revealed on job dissatisfaction ($t = 3.37$, $P \leq .001$) (Table 9.10).

The indication here is that females were slightly dissatisfied with some aspects of their working conditions while the males seemed to indicate moderate satisfaction.

Table 9.8

T-Test on Academic Qualifications of Occupational Therapists with Regard to Combined Role Autonomy Scales

			Pooled Variance Estimate		
Groups	N of Cases	Mean	T-Value	DF	2-tail P
Diploma Holders	21	4.615	-3.66	56	.001**
Degree Holders	37	5.216			

** P ≤ .01.

Table 9.9

T-Test on Sex of Physical Therapists with Regard to Professional Knowledge Scale 1

			Pooled Variance Estimate		
Groups	N of Cases	Mean	T-Value	DF	2-tail P
Male	5	3.00	-2.09	65	.04*
Female	65	3.63			

* P ≤ .05.

Table 9.10

T-Test on Sex of Physical Therapists
with Regard to Job Dissatisfaction Scale

Groups	N of Cases	Mean	Pooled Variance Estimate		
			T-Value	DF	2-tail P
1. Male	5	5.410	3.37	65	.001**
2. Female	62	3.90			

** P ≤ .01.

Table 9.11

T-Test on Age of Physical Therapists
with Regard to Combined Role Autonomy Scales

Groups	N of Cases	Mean	Pooled Variance Estimate		
			T-Value	DF	2-tail P
1. under 35 years	49	4.583	-2.44	54.76	.018*
2. over 35 years	19	4.998			

* P ≤ .05.

Age

The various age ranges were collapsed into two groups -- Group 1 for those under 35 years and Group 2 for those over 35. The T-test utilized on each of the individual scales revealed no statistically significant values.

When the test was performed on the combined scales, a value of statistical significance was revealed on role autonomy scales ($t = -2.44$, $\underline{P} \leq .018$) (Table 9.11).

Respondents over thirty-five years of age appeared to show a higher preference for role autonomy than respondents who were under this age group.

Marital Status

There were three groups under this variable. Group 1 was for single, Group 2 for married and Group 3 for widowed, divorced or separated. One-way analysis of variance performed revealed a significant difference in their opinions toward job dissatisfaction (F Ratio = 3.34, $\underline{P} \leq .042$) (Table 9.12). When the Scheffe procedure was employed, Group 3 (i.e., the widowed, divorced or separated) was found to differ significantly from Groups 1 and 2. Group 3 seemed to have indicated a higher degree of satisfaction than either of the other groups. However, it must be remembered that there were only two respondents in Group 3.

Table 9.12

One-Way Analysis of Variance on Marital Status of Physical Therapists with Regard to Job Dissatisfaction Scale

Groups	Count	Mean	F Ratio	F Prob.
1	15	3.580	3.34	.042*
2	50	4.072		
3	2	5.400		

Scheffe procedure: Group 3 significantly different at .100 level

* $P \leq .05$.
Group 1 = Single; Group 2 = Married; Group 3 = Widowed, divorced or separated.

Table 9.13

One-Way Analysis of Variance on Positions of Physical Therapists with Regard to Job Satisfaction Scale 2

Groups	Count	Mean	F Ratio	F Prob.
1	20	5.08	3.443	.038*
2	35	4.66		
3	6	4.42		

Scheffe procedure: Group 1 significantly different at .100 level

* $P \leq .05$.
Group 1 = Directors, Asst. Directors and Senior Therapists.
Group 2 = Staff Therapists I & II and Physiotherapists.
Group 3 = Owner Operators.

Present Position

Three groups were categorized under this rubric. Group 1 included the directors, assistant directors, and senior therapists; Group 2 were the staff therapists (Grades I and II) and the physiotherapists; while Group 3 constituted only the owner operators. When this variable (Present Position) was controlled for their responses to all the individual scales used in the study, the analysis of variance performed revealed a significant difference in their opinions toward job satisfaction scale 2 (F ratio = 3.443, $\underline{P} \leq .038$) (Table 9.13). The Scheffe procedure showed that Group 1 (i.e., Directors, Asst. Directors and Senior Therapists) differed significantly from Groups 1 and 2. The findings suggested that this group were more satisfied with the job satisfaction scale 2 than any of the other two groups.

When ANOVA was utilized, on the combined scales, a significant difference in opinions was found with the job dissatisfaction scale (F ratio = 6.630, $\underline{P} \leq .003$) (Table 9.14). The Scheffe procedure revealed that Group 3 (i.e., owner operators) differed significantly from either Groups 1 or 2. It can therefore be inferred that the owner operators showed more satisfaction with this dimension than any of the other groups.

Table 9.14

One-Way Analysis of Variance on Positions of Physical Therapists with Regard to Job Dissatisfaction Scale

Groups	Count	Mean	F Ratio	F Prob.
1	20	4.420		
2	35	3.554	6.630	.003**
3	6	4.647		

Scheffe procedure: Group 3 significantly different at .100 level

** $P \leq .01$.

Group 1 = Directors, Assistant Directors and Senior Therapists.
Group 2 = Staff Therapists I and II and Physiotherapists.
Group 3 = Owner Operators.

Academic Qualifications

Two distinct groups came out from the analysis of data on this variable--Group 1 (Diploma holders) and Group 2 (Degree holders). As found earlier with the occupational therapists, there was no respondent with a higher qualification than the ones above.

T-test was employed on each of the individual scales and four of these scales were found to have values of statistical significance. They are: role autonomy scale 1 (t = -2.03, $\underline{P} \leq .047$) (Table 9.15); professional knowledge scale 2 (t = -2.10, $\underline{P} \leq .04$) (Table 9.16); professional knowledge scale 3 (t = -2.04, $\underline{P} \leq .045$) (Table 9.17); and service ideal scale 5 (t = -2.90, $\underline{P} \leq .005$) (Table 9.18).

The Degree holders indicated from the above tests that they were higher in agreement than the Diploma holders with role autonomy scale 1, professional knowledge scale 2 and the service ideal scale 5 while the Diploma holders showed a higher level of agreement with professional knowledge scale 2.

When the T-test was applied to the combined scales, the role autonomy scales revealed the only value of statistical significance in the opinions of Degree holders (t = -2.04, $\underline{P} \leq .04$) (Table 9.19). The inference from this finding revealed that the Degree holders indicated a higher level of agreement for role autonomy than the Diploma holders.

Table 9.15

T-Test on Academic Qualifications of Physical Therapists
to Role Autonomy Scale 1

			Pooled Variance Estimate		
Groups	N of Cases	Mean	T-Value	DF	2-tail *P*
Diploma	37	4.32	-2.03	63	.047*
Degree	28	4.78			

* *P* ≤ .05

Table 9.16

T-Test on Academic Qualifications of Physical Therapists
to Professional Knowledge Scale 2

			Pooled Variance Estimate		
Groups	N of Cases	Mean	T-Value	DF	2-tail *P*
Diploma	37	5.03	2.10	63	.04*
Degree	28	4.65			

* *P* ≤ .05.

Table 9.17

T-Test on Academic Qualifications of Physical Therapists to Professional Knowledge Scale 3

Groups	N of Cases	Mean	Pooled Variance Estimate		
			T-Value	DF	2-tail P
Diploma	37	3.81	-2.04	63	.045*
Degree	28	4.50			

* P ≤ .05.

Table 9.18

T-Test on Academic Qualifications of Physical Therapists to Service Ideal Scale 5

Groups	N of Cases	Mean	Pooled Variance Estimate		
			T-Value	DF	2-tail P
Diploma	37	3.46	-2.90	59	.005**
Degree	24	4.75			

** $P \leq .01$.

Table 9.19

T-Test on Academic Qualifications of Physical Therapists to Combined Role Autonomy Scales

Groups	N of Cases	Mean	Pooled Variance Estimates		
			T-Value	DF	2-tail P
Diploma	37	4.55	-2.04	63	.04*
Degree	28	4.95			

* $P \leq .05$.

Data Analysis of Responses to Other Variables

This section considers the responses of occupational and physical therapists to variables that scored below the factor loadings greater than or equal to .35 considered significant by the SPSS subprogram. The results of the findings are presented below.

On item No. 32 in the original questionnaire, ten occupations were listed in which respondents were required to rank them according to the way in which they thought the public evaluated their social standing. A number "1" was to be placed opposite the occupation to which the public attributed the highest social standing through to "10"--the occupation in the group to which the public attributed the lowest social standing.

The results are presented in Tables 9.20 and 9.21. One interesting finding was that the occupational and physical therapists accorded the same ranking to six of the ten occupations. They both agreed in their responses that the physicians occupied the pride of place among the occupations while the hospital secretary was attributed the lowest social standing.

On the way the groups saw themselves and each other, the occupational therapists thought they ranked number six while they accorded number two to the physical therapists. The physical therapists, on the other hand, scored themselves number four while they accorded number six to the

Table 9.20

Data Analysis of Occupational Therapists' Responses To Questionnaire Item No. 32 (N = 62)

Name	Mean	Standard Deviation	Rank
Physicians	1.000	0.000	1*
Hospital Secretary	9.443	1.555	10*
Dieticians	6.508	1.840	7*
Prof. Social Workers	4.306	2.053	4
School Teachers	4.148	2.104	3
Physiotherapists	3.935	1.470	2
Lab. Technologists	7.902	1.422	9*
Registered Nurses	4.500	2.031	5
Registered Occ. Therapists	5.645	1.891	6*
Radiographers	7.283	2.001	8*

* Denotes agreement in ratings by occupational and physical therapists.

Table 9.21

Data Analysis of Physical Therapists' Responses To Questionnaire Item No. 32 (N = 68)

Name	Mean	Standard Deviation	Rank
Physicians	1.000	0.000	1*
Hospital Secretary	9.615	1.422	10*
Dieticians	6.723	2.118	7*
Prof. Social Workers	4.969	2.165	5
School Teachers	3.292	1.720	2
Physiotherapists	4.538	1.336	4
Lab. Technologists	7.262	1.770	9*
Registered Nurses	3.846	1.770	3
Registered Occ. Therapists	6.462	1.611	6*
Radiographers	7.246	1.929	8*

* Denotes agreement in ratings by occupational and physical therapists.

occupational therapists (the same way the latter ranked themselves).

From this finding, occupational therapists seemed to have expressed considerable dissatisfaction with the recognition they perceived was given to them by the general public. This result tallies with the findings of Maxwell and Maxwell (1977) in their final report of the Queen's University Study of Occupational Therapy. On the other hand, the physical therapists seemed to be relatively well off by this rating.

The data presented below refer to Tables 9.22, 9.23, 9.24 and 9.25. On item number two in Section C of the original questionnaire, the respondents were asked whether they felt more confident working with patients who had been referred to them by medical doctors. 51.7% of the occupational therapists agreed with the statement while 82.2% of the physical therapists agreed.

A closer examination of this item revealed that 6.5% of the occupational therapists agreed strongly with the statement while a considerable 38.2% of the physical therapists agreed strongly.

On the issue of whether both groups should have final authority over their work, 93.5% of the occupational therapists agreed while 88.2% of the physical therapists agreed. An inference from this finding is that both groups preferred to have their colleagues as references over the quality of their work.

Table 9.22

Mean ($\overline{X}$), Standard Deviation (SD), Mode (M) and Median (Md) of Occupational Therapists' Responses to Other Variable Items
(N = 62)

Item No.	$\overline{X}$	SD	M	Md
2. I feel more confident working with patients who have been referred to me by medical doctors.	3.533	1.432	4.00	3.643
5. Occupational therapists should have final authority over their work.	5.131	.974	6.00	5.295
9. Many professions are provincially licensed with a licensure examination and, in some cases, occupational therapist is licensed at the provincial level. To what extent do you agree that occupational therapists should be licensed by examination in Alberta?	4.274	1.591	6.00	4.500
10. Membership in the provincial association should be a requirement to practice or hold a position.	5.226	1.047	6.00	5.561
21. The best interests of occupational therapists would be served by conforming to professional standards rather than to standards of their employing institutions.	4.717	1.166	5.00	4.868
27. Occupational therapists should be involved in determining the program which will best meet patient care objectives.	5.613	.610	6.00	5.744

Table 9.23

Frequency Distribution of the Occupational Therapists' Responses to Other Variable Items (N = 62)

Category	Abbreviated Other Variable Items 2 %	 5 %	 9 %	 10 %	 21 %	 27 %
1 Strongly Disagree	8.1	—	8.1	—	1.6	—
2	19.4	3.2	6.5	1.6	1.6	—
3	17.7	1.6	16.1	9.7	11.3	1.6
4	22.6	16.1	19.4	6.5	22.6	1.6
5	22.6	35.5	19.4	29.0	30.6	30.6
6 Strongly Agree	6.5	41.9	30.6	53.2	29.0	66.1
Missing Values	3.2	1.6	—	—	3.2	—

Table 9.24

Mean ($\overline{X}$), Standard Deviation (SD), Mode (M) and Median (Md) of Physical Therapists' Responses to Other Variable Items
(N = 68)

Item No.	$\overline{X}$	SD	M	Md
2. I feel more confident working with patients who have been referred to me by medical doctors.	4.939	1.108	6.00	5.150
5. Physical therapists should have final authority over their work.	5.238	.946	6.00	5.574
9. Many professions are provincially licensed with a licensure examination, and in some cases, physical therapist is licensed at the provincial level. To what extent to dyou agree that physical therapists should be licensed by examination in Alberta?	4.134	1.817	6.00	4.417
10. Membership in the provincial association should be a requirement to practice or hold a position.	5.368	1.145	6.00	5.444
21. The best interests of physical therapists would be served by conforming to professional standards rather than to standards of their exploying institutions.	5.060	1.099	6.00	5.353
27. Physical therapists should be involved in determining the program which will best meet patient care objectives.	5.672	.561	6.00	5.802

Table 9.25

Frequency Distribution of the Physical Therapists' Responses to Other Variable Items
(N = 68)

Category	Abbreviated Other Variable Items					
	2 %	5 %	9 %	10 %	21 %	27 %
1 Strongly Disagree	—	—	10.3	2.9	1.5	—
2	2.9	—	11.8	1.5	—	—
3	8.8	4.4	19.1	1.5	7.4	—
4	17.6	19.1	8.8	10.3	19.1	4.4
5	29.4	19.1	10.3	17.6	25.0	23.5
6 Strongly Agree	38.2	50.0	38.2	66.2	45.6	70.6
Missing Values	2.9	7.4	1.5	—	1.5	1.5

Question number nine (Section C) asked whether occupational therapists and physical therapists should be licensed by examination in Alberta as other professions were provincially licensed with a licensure examination. 69.4% of the occupational therapists agreed while 57.3% of the physical therapists answered in the affirmative.

Of those that answered in the affirmative, 30.6% felt strongly among the occupational therapists while 38.2% of the physical therapists felt the same way. One can infer from the findings that both groups agreed that such a licensure examination is a way of ensuring the competency of their practicing members.

Item number 10 (Section C) asked whether membership in the provincial association should be a requirement to practice or hold a position. There was an overwhelming agreement from both sides (88.7% for occupational therapists and 94.1% for physical therapists). This results appears to confirm the perceptions of many therapists that memberships in the provincial association would tend to eliminate pretenders or quacks.

Item number 21 (Section C) asked whether occupational and physical therapists' best interests would be served by conforming to professional standards rather than to standards of their employing institutions. Both groups were very vocal in their agreement. Occupational therapists agreed with 82.2% while physical therapists agreed with 89.7%. Of these numbers, 29.0% and 45.6% strongly agreed, respectively.

From this finding it appeared that both groups would like to be divested of the restraining regulations found in most bureaucratic organizations.

Item number 27 (Section C) stated that occupational and physical therapists be involved in determining the program which will best meet patient care objectives. Occupational therapists agreed with 98.3% while 98.5% of the physical therapists concurred with the same view. In fact, 66.1% and 70.6%, respectively, agreed strongly.

There is no gain-saying the fact that both groups saw that this would enable them to make more positive evaluation, would lead to demand for more occupational and physical therapy services and would give more frequent requests for the opinions of the groups in policy decisions.

PART IV

INTERPRETATION AND IMPLICATIONS

CHAPTER X

SUMMARY AND IMPLICATION OF FINDINGS

CHAPTER X

SUMMARY AND IMPLICATIONS OF FINDINGS

The primary aim of this study was to determine the attitudes of occupational and physical therapists toward role autonomy. In order to probe this objective further, several sub-objectives were formulated. Hypotheses were developed to obtain the necessary information for either the confirmation, partial confirmation or rejection of the research objectives.

Data for the study were gathered from registered, active members of the Alberta Association of Registered Occupational Therapists (AAROT) and the Association of Chartered Physiotherapists of Alberta (ACPA).

A summation of the results of each of these research objectives is given in the first section of this chapter. Implications of these results for further practice and research are then presented.

Summary

RO_1 The first research objective was to determine the degree to which occupational therapists would prefer role autonomy. As previously explained, role autonomy was defined by Freidson (1970) as the degree to which work could be carried on independently of organizational or medical supervision.

RH_1 It was hypothesized that there would be a preference for role autonomy (i.e., in areas of practice, control and organization) by registered occupational therapists in Alberta.

The results revealed that registered occupational therapists in Alberta showed a strong preference for role autonomy. (CONFIRMED)

RO_2 The second research objective was to determine the degree to which physical therapists would prefer role autonomy.

RH_2 The derived hypothesis from the second objective was that there would be a preference for role autonomy (i.e., in areas of practice, control and organization) by registered physical therapists in Alberta.

The results indicated that physical therapists preferred role autonomy only in areas of control and organization but not in practice. (PARTIALLY CONFIRMED)

RO_3 The third research objective was to determine the degree to which occupational and physical therapists have similar opinions toward role autonomy scales.

Following the results of the factor analyses, this study explored further significant differences in the opinions of occupational and physical therapists toward job satisfaction, job dissatisfaction, professional knowledge and service ideal scales. Hypotheses were therefore derived to obtain necessary information for the above.

RH_{3a} The first research hypothesis stated that there would be no significant differences between the opinions of occupational and physical therapists toward role autonomy scales.

The result of the T-test analysis showed that occupational therapists preferred a higher degree of role autonomy than the physical therapists. (REJECTED)

RH_{3b} Secondly, it was hypothesized that there would be no significant differences between the opinions of occupational and physical therapists toward job satisfaction scales.

T-test results revealed that both groups seemed to be moderately satisfied with the job satisfaction aspects of their working conditions. (CONFIRMED)

RH_{3c} The third hypothesis indicated that there would be no significant differences between the opinions of occupational and physical therapists toward job dissatisfaction scale.

Results revealed no evidence of significant differences in their opinions. They seemed to indicate the same degree of slight satisfaction with these aspects of their working conditions. (CONFIRMED)

RH_{3d} The fourth hypothesis stated that there would be no significant differences between the opinions of occupational and physical therapists toward professional knowledge scales.

The results showed a significant difference in their opinions. Occupational therapists indicated a stronger preference for a higher level of professional knowledge than the physical therapists. (REJECTED)

RH_{3e} The fifth hypothesis indicated that there would be no significant differences between the opinions of occupational and physical therapists toward service ideal scales.

The findings showed that no significant differences existed in their opinions toward the scales. Both groups had expressed the same slight degree of agreement with the service ideal of their professions. (COMFIRMED)

RO_4 The fourth research objective was to determine the nature of relationship, if any, between the degree of orientation the occupational therapists have toward professionalism (i.e., knowledge and service) and their degree of orientation toward role autonomy scales.

RH_4 It was hypothesized that there would be a positive relationship between the orientation of occupational therapists toward role autonomy scales and their orientation toward professionalism (i.e., knowledge and service ideal).

Results indicated that occupational therapists' orientation toward role autonomy was positively related to their orientation toward professionalism. The therapists seemed to agree that preference for role autonomy should be accompanied with improvement in professional knowledge and service ideal. (CONFIRMED)

RO_5 This research objective was to determine the nature of relationship, if any, between the degree of orientation the physical therapists have toward role autonomy scales and their degree of orientation toward professionalism (i.e., knowledge and service) scales.

RH_5 The derived hypothesis stated that there would be a positive relationship between the orientation of physical therapists toward role autonomy scales and their orientation toward professionalism scales.

The results indicated that physical therapists' orientation toward role autonomy scales was positively related to their orientation toward the knowledge scales and negatively related to their orientation toward service ideal scales. The therapists seemed to agree that preference for role autonomy should be accompanied only with improvement in professional knowledge. (PARTIALLY CONFIRMED)

RO_6 The research objective was to determine the nature of relationship, if any, between the degree of orientation the occupational therapists have toward role autonomy scales and their orientation toward job dissatisfaction scale.

RH_6 It was hypothesized that the occupational therapists' orientation with respect to role autonomy scales will be positively related to their orientation toward job dissatisfaction scale.

Results confirmed the existence of positive relationship between occupational therapists' orientation toward role autonomy scales and dissatisfaction scale. The indication here is that occupational therapists' preference for role autonomy has been determined partly by their dissatisfaction with certain aspects of their work. (CONFIRMED)

RO_7 The seventh research objective was to determine the nature of relationship, if any, between the degree of orientation the physical therapists have toward role autonomy scales and their orientation toward job dissatisfaction scale.

RH_7 The derived hypothesis indicated that physical therapists' orientation with respect to role autonomy scales would be positively related to their orientation toward job dissatisfaction scale.

The findings showed that there was a negative relationship between the orientation of physical therapists toward role autonomy scales and their orientation to job dissatisfaction scale. The inference from this result seemed to indicate that the therapists' lack of preference for role autonomy was not attributable to any dissatisfaction in their work. (REJECTED)

RO_8 The eighth research objective was to determine the nature of relationship, if any, between the degree of orientation the occupational therapists have toward role autonomy scales and their orientation toward job satisfaction scales.

RH_8 The accompanying hypothesis stated that occupational therapists' orientation with respect to role autonomy scales would be positively related to their orientation toward job satisfaction scales.

The results showed that the above hypothesis was supported. The indication is that occupational therapists' preference for role autonomy has been partly determined by satisfaction with their work. (COMFIRMED)

RO_9 The ninth research objective was to determine the nature of relationship, if any, between the degree of orientation the physical therapists have toward role autonomy and their orientation toward job satisfaction scales.

RH_9 It was hypothesized that physical therapists' orientation with respect to role autonomy scales would be positively related to their orientation toward job satisfaction scales.

The results showed that physical therapists' orientation toward role autonomy scales was negatively related to their orientation toward job satisfaction scales. The therapists have therefore indicated that the lack of preference for role autonomy has nothing to do with satisfaction from their work. (REJECTED)

Implications

It was interesting to find out from the results of this study that among the occupational therapists sampled, role autonomy was endorsed both in general and specific forms by a large majority. This appeared to be a reversal to the findings of Lehmann's (1973) study.

Lehmann (1973) found that most occupational therapists sampled did not agree that the physician's referral or prescription should not be required for delivery of occupational therapy services. In this study, over 60% of occupational therapists indicated their disagreement with this particular issue. He also found a greater advocacy for role autonomy by unmarried occupational therapists. This study found that married therapists have now led the quest for increased general independence.

Despite their support of increased general independence, most physical therapists unexpectedly rejected the idea that their services should not require a physician's referral or prescription. However, responses to the issue of referral or prescription differed by educational qualifications of the respondents. Opposition to services without the physician's referral or prescription was especially prevalent among the physical therapists who hold diploma certificates.

Generally, the central issue in the problem of autonomy at the level of the individual practitioner is the therapists' relationship to the physician. As has been noted in literature review, the medical profession was instrumental in the early development of occupational and physical therapy professions and the relationship extended to the therapeutic setting. The physician's prescription has since remained, however, as a symbol of his control over treatment and is apparently a thorny reminder of the therapists' subordinate status.

Among all the possible implications which can be drawn from the results of the present study, the one which deserves priority, obviously has to do with the design of an appropriate model of autonomy structure for emerging professions like occupational and physical therapy.

If occupational therapists and, to a lesser extent, the physical therapists are now showing signs of highly professionally-oriented groups--that is, groups oriented toward service, knowledge and autonomy--it is perhaps at the demand of the public itself.

Indeed, the therapists have been asked to become more competent; they have been told to become better prepared academically if they wish to be granted professional status.

Advanced training will provide the impetus for the therapists to challenge the organizational rules which may prevent them from becoming involved in health care decision-making. Indeed, the time has now come for the public and their representatives to welcome the desire by the therapists for more involvement in decision-making as a sign that the professions are now maturing.

Another implication of the findings points to the necessity of re-examining the authority structure of the health care systems. Physicians must begin to realize that its traditional domination of the medical profession must be altered to meet this new reality called "the professionalization of the occupational and physical therapists."

Perhaps, legislation may be required to respond to this phenomenon by implementing laws which redefine the areas of administrative and professional responsibilities. If there is no attempt to restructure the power structure within the medical field, one could expect sooner or later an ever-increasing conflict of power equalization between the therapists and the physicians. Like an unknowing victim of future shock which Toffler (1979) warned, the physician "may awake one morning to find his specialty obsolete or else transformed beyond recognition by events exploding outside his field of vision" (p. 359).

However, many problems may be foreseen in implementing such autonomy structure. One that stands out is an agreement on the nature of the supervisory dimension of authority to be reached. In the face of such important problems would be the task to design a collegial decision-making structure wherein the therapists and the physicians could jointly reach agreement over decisions of a professional nature.

For Further Research

Research may be needed to develop and improve instruments which would measure with greater accuracy occupational and physical therapy attitudes toward autonomy, service and knowledge.

Further research similar to the one undertaken in the present study should be done in order to determine what medical administrators, lay people, and students think are and should be the autonomous areas of occupational and physical therapists.

BIBLIOGRAPHY

BIBLIOGRAPHY

Allbon, L.G. Some divisive forces in occupational therapy. Canadian Journal of Occupational Therapy, 1975, 42(3), 89-90.

Allen, S.A. and Cruickshank, D.R. Perceived problems of occupational therapists: A subset of the professional curriculum. American Journal of Occupational Therapy, 1977, 31(9), 557-564.

American Occupational Therapy Association. Statement on proficiency and equivalency standards, American Journal of Occupational Therapy, 1973, 27(7), 411.

American Occupational Therapy Association. Statement on advanced professional education. American Journal of Occupational Therapy, 1973, 27(3), 158.

American Physical Therapy Association. Report of the house of delegates session. Physical Therapy, 1979, 59(11), 1396-1400.

American Physical Therapy Association. Policy statement on recognition of specialists in physical therapy. Physical Therapy, 1975, 55(11), 1216-1217.

Barnes, M.R. and Crutchfield, C.A. Job satisfaction-dissatisfaction: A comparison of private practitioners and organizational physical therapists. Physical Therapy, 1977, 57(1), 35-40.

Bartlett, R.C. The 1979 presidential address. Physical Therapy, 1979, 59(11), 1378-1387.

Bartlett, R.C. The 1978 presidential address. Physical Therapy, 1978, 58(11), 1325-1333.

Basmajian, J.V. Professional survival--the research role in physical therapy. Physical Therapy, 1977, 57(3), 283-285.

Borg, W.R. and Gall, M.D. Educational research--an introduction. New York: David McKay Company, Inc., 1971.

Brayley, C.R. Mobilization of membership for legislative action. American Journal of Occupational Therapy, 1976, 30(1), 31.

Bridle, M.J. Standards--who needs them? Setting standards for the education of occupational therapists. Canadian Journal of Occupational Therapy, 1979, 46 (5), 206-210.

Brunyate, R.W. Nationally speaking. American Journal of Occupational Therapy, 1969, 23(3), 209-212.

Cardwell, T. President's address. Canadian Journal of Occupational Therapy, 1966, 33(4), 139-140.

Cattell, R.B. Factor analysis. New York: Harper & Row, 1952.

Child, D. The essentials of factor analysis. New York: Holt Rinehart and Winston, 1970.

Christiansen, C.H. Attitudes of graduates toward occupational therapy education. American Journal of Occupational Therapy, 1975, 29(6), 352-355.

Clark, D.D. A clinician's views of specialization. American Journal of Occupational Therapy, 1979, 33(1), 36-37.

Conte, J.R. and Conte, W.R. The use of conceptual models in occupational therapy. American Journal of Occupational Therapy, 1977, 31(4), 262-265.

Dawes, R.M. Fundamentals of attitude measurement. New York: John Wiley and Sons, Inc., 1972.

Dunning, E.R. An accountability model for occupational therapy. American Journal of Occupational Therapy, 1975, 29(1), 35-38.

Dunning, R.E. Philosophy and occupational therapy. American Journal of Occupational Therapy, 1973, 27(1), 18-23.

Etzioni, A. The semi-professions and their organization. New York: The Free Press, 1969.

Fidler, G. Specialization: Implications for education. American Journal of Occupational Therapy, 1979, 33(1), 34-35.

Fidler, G.S. From plea to mandate. American Journal of Occupational Therapy, 1977, 31(10), 653-655.

Fidler, G.S. Learning as a growth process: A conceptual framework for professional education. American Journal of Occupational Therapy, 1966, 20(1), 1-8.

Fiorentino, M.R. Occupational therapy: Realization to activation, 1974 Eleanor Clarke Slagle Lecture. American Journal of Occupational Therapy, 1975, 29(1), 15.

Franks, R. Editorial 1935. Canadian Journal of Occupational Therapy, 1979, 46(1), 10.

Freidson, E. Profession of medicine--a study of the sociology of applied knowledge. New York: Dodd, Mead & Company, 1970.

Gilewich, G.B. Muriel Driver Memorial Lecture: Managers in occupational therapy. Canadian Journal of Occupational Therapy, 1979, 46(4), 131-137.

Gillete, N. and Kielhofner, G. The impact of specialization on the professionalization and survival of occupational therapy. American Journal of Occupational Therapy, 1979, 33 (1), 20-28.

Gillian, M.B.K. Developmental stages of occupational therapy and the feminist movement. American Journal of Occupational Therapy, 1976, 30(9), 560-567.

Goetz, L.J. Are physical therapists assuming a passive role in the care of their patients? Physical Therapy, 1978, 58(5), 624-625.

Granger, F.B. The beginning of "Modern Physiotherapy." Physical Therapy, 1976, 56(1), 15-21.

Helewa, A. CPA 1979 Congress - Presidential address. Physiotherapy Canada, 1979, 31(1), 41-43.

Herzberg, F. Work and the nature of man. Ohio: The World Publishing Company, 1971.

Hightower-Vandamm, D.M. Nationally speaking--the far reaching impact of the renaissance. American Journal of Occupational Therapy, 1979, 33(12), 757-761.

Hightower-Vandamm, D.M. Future occupational therapy--fact or fancy? Canadian Journal of Occupational Therapy, 1979, 46(4), 139-142.

Hislop, H.J. Tenth Mary McMillan Lecture: The not-so-impossible dream. Physical Therapy, 1975, 55(10), 1069-1080.

Hillbrath, S.C. Licensure in Florida--the beginning of policital involvement. American Journal of Occupational Therapy, 1976, 30(1), 35-39.

Hoffman, M.A. Continuing education: Avoiding professional obsolescence. Physiotherapy Canada, 1979, 31(3), 143-146.

Hoffman, M.A. Continuing education--an answer to professional obsolescence. Canadian Journal of Occupational Therapy, 1979, 46(5), 211-213.

Holmstrom, E.I. Promising prospects--students choosing therapy as a career. American Journal of Occupational Therapy, 1975, 29(10), 608-614.

Hood, M.R. Muriel Driver Memorial Lecture. Canadian Journal of Occupational Therapy, 1976, 43(3), 105-111.

Hoy, W.K. and Miskel, C.G. Educational administration: theory, research and practice. New York: Random House, Inc., 1978.

Hunter, J.E. Research and occupational therapy. Canadian Journal of Occupational Therapy, 1976, 43(3), 121-125.

Illich, I., Zola, K.I., McKnight, J., Caplan, J. and Shaiken, H. Disabling professions. Marion Boyars, Burns & MacEachern, 1977.

Jantzen, A.C. A proposal for occupational therapy education. American Journal of Occupational Therapy, 1977, 31(10), 660-662.

Jantzen, A.C. Some characteristics of male occupational therapists, 1970. American Journal of Occupational Therapy, 1973, 27(7), 388-391.

Jarvis, H. From the president's desk. Canadian Journal of Occupational Therapy, 1979, 46(5), 179-180.

Johnson, J.A. Nationally-speaking--humanitarianism and accountability - A challenge for occupational therapy on its 60th anniversary. American Journal of Occupational Therapy, 1977, 31(10), 631-637.

Johnson, J.A. Challenges confronting occupational therapy. Canadian Journal of Occupational Therapy, 1977, 44(3), 113-117.

Johnson, J.A. The Eleanor Clarke Slagle Lecture--Occupational therapy, a model for the future. American Journal of Occupational Therapy, 1973, 27(1), 1-7.

Katz, F.E. Autonomy and organization--the limits of social control. New York: Random House, 1968.

Kemp, N.I., Scholz, C.A., Stanford, T.L. and Shepard, K.F. Salary and status differences between male and female physical therapists. *Physical Therapy*, 1979, *59*(9), 1095-1101.

Kerlinger, F.N. *Foundations of behavioral research.* New York: Holt, Rinehart & Winston, Inc., 1973.

Kielhofner, G. and Burke, P.J. Occupational therapy after 60 years--an account of changing indentity and knowledge. *American Journal of Occupational Therapy*, 1977, *31*(10), 675-689.

Killian, R.A. *The working woman.* American Management Association, 1971.

Killian, R.A. *The working woman--a male manager's view.* American Management Association, 1971.

Lehmann, L. Occupational therapists' attitudes toward role autonomy. *American Journal of Occupational Therapy*, 1973, *27*(7), 384-386.

Lewis, R. and Maude, A. *Professional people.* London: Phoenix House Ltd., 1952.

Lewis, C.E. The quandary of quality--incompetence among the excellent. *American Journal of Occupational Therapy*, 1973, *27*(2), 59-63.

Lieberman, J.K. The tyranny of the experts. New York: Walker and Company, 1970.

Lubkowski, J. The dilemma of a diploma graduate. *Physiotherapy Canada*, 1974, *26*(1), 30-31.

Lucci, J.A. The basic master's degree program in occupational therapy. *American Journal of Occupational Therapy*, 1974, *28*(5), 292-295.

Maas, M., Specht, J. and Jacox, A. Nurse autonomy--reality not rhetoric. *American Journal of Nursing*, 1975, *74*(12), 2201-2208.

Magistro, C.M. The 1976 presidential address. *Physical Therapy*, 1976, *55*(11), 1227-1239.

Magistro, C.M. The 1975 presidential address. *Physical Therapy*, 1975, *55*(11), 1199-1208.

Massé, D. *Teacher participation and professional attitudes.* Unpublished doctoral dissertation, University of Alberta.

Mathewson, M. Female and married--damaging to the therapy profession? *American Journal of Occupational Therapy*, 1975, *29*(10), 601-605.

Mathewson, M. The female physiotherapist after marriage--is she wasted? Physiotherapy Canada, 1974, 26(5), 273-276.

Maxfield, M.F. The effectiveness of master's degree programs for occupational therapists. American Journal of Occupational Therapy, 1975, 29(4), 213-218.

Maxwell, J.D. and Maxwell, M.P. Graduate education--the case of occupational therapy. Canadian Journal of Occupational Therapy, 1979, 46(5), 189-196.

Maxwell, J.D. The Queen's University study of occupational therapy--some reflections and conclusions. Canadian Journal of Occupational Therapy, 1977, 44(3), 137-139.

McCordic, L. Factors influencing the education of occupational therapists in Ontario. Canadian Journal of Occupational Therarpy, 1975, 42(3), 97-103.

National Manpower Council. Work in the lives of married women. New York: Columbia University Press, 1958.

Nicolais, J.P. Policy development and strategy in the licensure of speech pathologists and audiologists. American Journal of Occupational Therapy, 1976, 30(1), 21-26.

Nie, N.H., Hull, C.H., Jenkins, J.G., Steinbrenner, K. and Bent, D.H. Statistical package for the social sciences 2nd edition. McGraw-Hill Book Company, 1975.

Ontario Physiotherapy Association. Referral debate makes headlines in Ontario. Physiotherapy Canada, 1979, 31(1), 41-43.

O'Shea, B.J. Me?--Political? Canadian Journal of Occupational Therapy, 1979, 46(4), 143-145.

O'Shea, B.J. Muriel Driver Memorial Lecture: Pawn or protagonist--interactional perspective of professional identity. Canadian Journal of Occupational Therapy, 1977, 44(3), 101-108.

Pady, A. The proposal viewed by a degree graduate. Physiotherapy Canada, 1974, 26(1), 29-30.

Pavalko, R.M. Sociology of occupations and professions. Illinois: F.E. Peacock Publishers, Inc., 1971.

Pavalko, R.M. Sociological perspectives on occupations. Illinois: F.E. Peacock Publishers, Inc., 1971.

Purtilo, R.B. Who should make moral policy decisions in health care? Physical Therapy, 1978, 58(9), 1076-1081.

Purtilo, R.B. The American Physical Therapy Association's code of ethics--its historical foundations. Physical Therapy, 1977, 57(9), 1001-1006.

Reilly, M. The educational process. American Journal of Occupational Therapy, 1969, 13(4), 299-307.

Remmel-McKay, A.M. Sociological overview of professionalism in occupational therapy. Canadian Journal of Occupational Therapy, 1975, 42(3), 97-103.

Rogers, J.C. Design of a master's degree in occupational therapy, Part I - A logical approach. American Journal of Occupational Therapy, 1980, 34(2), 113-118.

Rosen, S. Are P.T.s assuming role of physicians? Physical Therapy, 1978, 58(1), 69-71.

Rowe, C. Perspectives from tomorrow's therapists. Canadian Journal of Occupational Therapy, 1979, 46(5), 113-114.

Semple, J.A. Degree vs Diploma--in support of a degree for full membership in the CPA. Physiotherapy Canada, 1974, 26(1), 28-29.

Seymour, R.J., Connelly, T. and Gardner, D. Continuing education--an attitudinal survey of physical therapists. Physical Therapy, 1979, 59(4), 399-404.

Scott, A. What direction physiotherapy education? The view of a clinical lecturer. Physiotherapy Canada, 1974, 26(3), 156-158.

Shannon, P.D. The derailment of occupational therapy. American Journal of Occupational Therapists, 1977, 31(4), 229-234.

Silver, G.A. Specialization and its implications. American Journal of Occupational Therapy, 1979, 33(1), 15-19.

Strauss, A.L. Professions, work and careers. New Jersey: Transaction Books, 1975.

Susman, G.I. Autonomy at work. New York: Praeger Publishers, Inc., 1976.

Tannenbaum, M. Is knowledge dangerous? Physical Therapy, 1978, 58(5), 624.

Tate, S.W. From the president's desk. *Canadian Journal of Occupational Therapy*, 1976, *43*(1), 7-8.

Tate, S.W. The scope for occupational therapists in the community in the future. *Canadian Journal of Occupational Therapy*, 1974, *41*(2), 7-9.

Toffler, A. *Future shock*. Bantam Books. New York: Random House, Inc., 1979.

Valentine, P.J. Specialization within the profession. *Physiotherapy Canada*, 1973, *25*(3), 131.

Vollmer, H.M. and Mills, L. *Professionalization*. New Jersey: Prentice-Hall, Inc., 1966.

Welles, C. Ethics in conflict--yesterday's standards--outdated guide for tomorrow? *American Journal of Occupational Therapy*, 1976, *30*(1), 44.

West, W.L. Problems and policies in the licensure of occupational therapy. *American Journal of Occupational Therapy*, 1976, *30*(1), 40-43.

Winston, E.I. Motivation for licensure. *American Journal of Occupational Therapy*, 1976, *30*(1), 27-30.

Woodside, H. Basic issues in occupational therapy education today. *Canadian Journal of Occupational Therapy*, 1977, *44*(1), 9-16.

Yerxa, E.J. Authentic occupational therapy. *American Journal of Occupational Therapy*, 1967, *21*(1), 1-9.

Yerxa, E.J. Nationally speaking--on being a member of a feminine profession. *American Journal of Occupational Therapy*, 1975, *29*(10), 597-598.

Zimmerman, T.F. Is professionalism the answer to improving health care? *American Journal of Occupational Therapy*, 1974, *28*(8), 465-468.

APPENDIX A

INSTRUMENTS OF RESEARCH

FACULTY OF EDUCATION
DEPARTMENT OF EDUCATIONAL
ADMINISTRATION

THE UNIVERSITY OF ALBERTA
EDMONTON, CANADA
T6G 2G5

February 19, 1980

Dear Occupational Therapist:

The attached questionnaire is part of a study designed to explore the attitudes of occupational therapists and Physiotherapists in Alberta with respect to their profession and work.

The questions mainly ask for your opinions; there are no right or wrong answers. I hope that you will be frank. Some of the questions may appear personal, but they are designed to help me give a useful interpretation of the results.

I am a qualified occupational therapist and this study is a requirement of partial fulfilment of my Master's degree in educational administration.

In advance I wish to thank you for your participation in this study. It is through cooperation in studies such as this that we can all advance our professional growth.

Yours sincerely,

Philip Ogunleye
B. Sc. (OT), B.M.A.O.T.

PO/jl
Attach.

SECTION A - GENERAL INFORMATION

1 ------- 1/4

1. SEX

1) ___ Male
2) ___ Female

cc
5

2. AGE

1) ___ 20 years or less
2) ___ 21-25 years
3) ___ 26-30 years
4) ___ 31-35 years
5) ___ 36-40 years
6) ___ 41-45 years
7) ___ 46-50 years
8) ___ 51-55 years
9) ___ 56-60 years
10) ___ 60 years and older

6 - 7

3. MARITAL STATUS

1) ___ Single
2) ___ Married
3) ___ Widowed, divorced or separated

8

4. YOUR PRESENT POSITION

1) ___ Director
2) ___ Supervisor
3) ___ Sole Charge Therapist
4) ___ Staff Therapist
5) ___ Private Practitioner
6) ___ Private Consultant
7) ___ Government Consultant
8) ___ Other (Specify)

____

9

5. YOUR ACADEMIC QUALIFICATIONS

1) ___ Diploma in Occ. Therapy
2) ___ Teaching Diploma in Occ. Therapy
3) ___ B.O.T. or B.Sc(O.T.)
4) ___ Masters degree
5) ___ Doctoral degree
6) ___ Other (Specify)

____

10

SECTION B

Please indicate the degree to which you are satisfied with each of the following items by checking a number on the scale:

Very Dissatisfied 1 2 3 4 5 6 Very Satisfied

	Very Dissatisfied 1	2	3	4	5	Very Satisfied 6	cc
1. The conditions under which you have to work (i.e., lighting, ventillation, space and equipment)							11
2. The opportunities for advancement in your position							12
3. The recognition you get from your job.							13
4. The amount of pay you get for doing your job.							14
5. The amount of job security you have in your position							15
6. Your control over the quality of your work							16
7. The amount of decision-making demanded by your position							17
8. The amount of responsibility demanded by your position							18
9. The extent to which you can use your skills							19
10. The feeling of accomplishment from the work you are doing							20
11. The opportunities to do the things you are really educated for (as opposed to those things that people with less training can do just as well)							21
12. The extent to which the medical doctors accept you as a colleague within the health care system							22
13. The cooperativeness you receive from other health care personnel in your institution							23
14. The adequacy of your present professional qualifications							24
15. The confidence in your professional ability which your patients have in you							25
16. The extent to which you are left relatively free of supervision by others.							26

SECTION C

Please indicate the degree to which you agree with each of the following statements by checking a number on the scale:

Strongly Disagree 1 2 3 4 5 6 Strongly Agree

	Strongly Disagree 1	2	3	4	5	Strongly Agree 6	cc
1. Occupational therapists should be permitted to terminate or continue the treatment of their patients as they deem fit.							27
2. I feel more confident working with patients who have been referred to me by medical doctors.							28
3. Occupational therapists should be responsible for developing the budget for occupational therapy departments in their facilities.							29
4. Occupational therapists should be responsible for developing staff projections for the occupational therapy departments in their facilities.							30
5. Occupational therapists should have final authority over their work.							31
6. Occupational therapists as members of a health care team should be allowed to function more independently.							32
7. Occupational therapists within medical settings should be allowed to provide their services to clients in need of those services without the requirement of a physician's referral or prescription.							33
8. Occupational therapists should be allowed to make their own decisions regarding problems that come up with the treatment of their patients.							34
9. Many professions are provincially licensed with a licensure examination and, in some cases, occupational therapist is licensed at the provincial level. To what extent do you agree that occupational therapists should be licensed by examination in Alberta?							35

cont'd...

SECTION C (cont'd)

	Strongly Disagree					Strongly Agree	cc
	1	2	3	4	5	6	
10. Membership in the provincial association should be a requirement to practise or hold a position							36
11. Membership in the national association should be a requirement to practise or hold a position							37
12. There should be a re-examination and re-licensing for any occupational therapist who wishes to re-enter practice after an absence of five years or more.							38
13. To what extent do you agree that occupational therapy as a profession has a firm core of theory and knowledge like medicine?							39
14. I sometimes do things that I should have been better prepared for in my course in occupational therapy.							40
15. Continuing education in occupational therapy should be developed to meet the future needs of the therapists.							41
16. Thinking of various jobs which occupational therapists may hold five to ten years from now, Alberta would need a Master's program in occupational therapy.							42
17. To what extent do you agree that university education in occupational therapy is adequate?							43
18. To what extent do you agree that occupational therapy education in a community college could be adequate to meet the training requirements of the profession?							44
19. It should be permissible for an occupational therapist to violate medical protocol if it is in the best interests of the patient.							45
20. I feel the need for someone with a higher level of expertise in occupational therapy in my facility.							46
21. The best interests of occupational therapists would be served by conforming to professional standards rather than to standards of their employing institutions.							47

cont'd...

SECTION C (cont'd)

	Strongly Disagree 1	2	3	4	5	Strongly Agree 6	cc
22. Occupational therapists should be made more accountable for the treatment activities of their patients.							48
23. To what extent did you agree that occupational therapy training prepared you to conduct and report research?							49
24. Occupational therapists should be evaluated only by their fellow occupational therapists.							50
25. Because of what I am able to do for society, I would like to continue in my present profession even if I could earn more money at another vocation.							51
26. My occupational therapy education prepared me adequately to carry out administrative/supervisory duties.							52
27. Occupational therapists should be involved in determining the program which will best meet patient care objectives.							53
28. Do you agree that occupational therapy as a profession may be threatened by the growth and development of other occupations or professions?							54
For questions 29, 30 and 31, please respond in relation to this statement: In many professions there are problems such as lack of power and influence, difficulty in relation to other professions etc. Thinking of O.T. :- 29. To what extent do you agree that the lack of a clearly defined area of competence in relation to other health professions account for some of the problems in occupational therapy profession?							55
30. To what extent do you agree that the lack of training of O.T.s in dealing with government and other professions account for some of the problems in the profession?							56
31. To what extent do you agree that the fact that the majority of people in the profession are women account for some of the problems in the profession?							57

cc

32. Listed below are ten occupations. Please rank them according to the way in which you think the public evaluates their social standing. Place the number "1" opposite the occupation to which you think the public attributes the highest social standing through to "10"--the occupation in the group to which you think the public attributes the lowest social standing.

___	Physicians	___	Hospital Secretary	58-59, 60-61
___	Dieticians	___	Prof. Social Workers	62-63, 64-65
___	School Teachers	___	Physiotherapists	66-67, 68-69
___	Laboratory Technologists	___	Registered Nurses	70-71, 72-73
___	Registered Occupational Therapists	___	Radiographers	74-75, 76-77

Comments (if any) ______________________________

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____

____

____

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If you would like a report of the findings of this study, please contact your Association's headquarters later.

Thank you.

FACULTY OF EDUCATION
DEPARTMENT OF EDUCATIONAL
ADMINISTRATION

THE UNIVERSITY OF ALBERTA
EDMONTON, CANADA
T6G 2G5

February 19, 1980

Dear Physiotherapist:

The attached questionnaire is part of a study designed to explore the attitudes of occupational therapists and Physiotherapists in Alberta with respect to their profession and work.

The questions mainly ask for your opinions; there are no right or wrong answers. I hope that you will be frank. Some of the questions may appear personal, but they are designed to help me give a useful interpretation of the results.

I am a qualified occupational therapist and this study is a requirement of partial fulfilment of my Master's degree in educational administration.

In advance I wish to thank you for your participation in this study. It is through cooperation in studies such as this that we can all advance our professional growth.

Yours sincerely,

Philip Ogunleye
B. Sc. (OT), B.M.A.O.T.

PO/jl
Attach.

SECTION A - GENERAL INFORMATION

1 -------- $\frac{2}{4}$

cc

1. SEX

1) ___ Male
2) ___ Female

5

2. AGE

1) ___ 20 years or less
2) ___ 21-25 years
3) ___ 26-30 years
4) ___ 31-35 years
5) ___ 36-40 years
6) ___ 41-45 years
7) ___ 46-50 years
8) ___ 51-55 years
9) ___ 56-60 years
10) ___ 60 years and older

6 - 7

3. MARITAL STATUS

1) ___ Single
2) ___ Married
2) ___ Widowed, divorced or separated

8

4. YOUR PRESENT POSITION

1) ___ Director
2) ___ Asst. Director
3) ___ Senior Therapist
4) ___ Staff Therapist II
5) ___ Staff Therapist I
6) ___ Physiotherapist
7) ___ Owner Operator
8) ___ Other (specify) ____________________

9

5. YOUR ACADEMIC QUALIFICATIONS

1) ___ Diploma in Pysiotherapy
2) ___ Teaching Diploma in Physiotherapy
3) ___ B.P.T. or B.Sc. (PT)
4) ___ Masters degree
5) ___ Doctoral degree
6) ___ Other (Specify) ____________________

10

SECTION B

Please indicate the degree to which you are satisfied with each of the following items by checking a number on the scale:

Very Dissatisfied 1 2 3 4 5 6 Very Satisfied

	Very Dissatisfied					Very Satisfied	cc
	1	2	3	4	5	6	
1. The conditions under which you have to work (i.e., lighting, ventillation, space and equipment)							11
2. The opportunities for advancement in your position							12
3. The recognition you get from your job.							13
4. The amount of pay you get for doing your job.							14
5. The amount of job security you have in your position							15
6. Your control over the quality of your work							16
7. The amount of decision-making demanded by your position							17
8. The amount of responsibility demanded by your position							18
9. The extent to which you can use your skills							19
10. The feeling of accomplishment from the work you are doing							20
11. The opportunities to do the things you are really educated for (as opposed to those things that people with less training can do just as well)							21
12. The extent to which the medical doctors accept you as a colleague within the health care system							22
13. The cooperativeness you receive from other health care personnel in your institution							23
14. The adequacy of your present professional qualifications							24
15. The confidence in your professional ability which your patients have in you							25
16. The extent to which you are left relatively free of supervision by others.							26

SECTION C

Please indicate the degree to which you agree with each of the following statements by checking a number on the scale:

Strongly Disagree 1 2 3 4 5 6 Strongly Agree

	Strongly Disagree 1	2	3	4	5	Strongly Agree 6	cc
1. Physiotherapists should be permitted to terminate or continue the treatment of their patients as they deem fit.							27
2. I feel more confident working with patients who have been referred to me by medical doctors.							28
3. Physiotherapists should be responsible for developing the budget for physiotherapy departments in their facilities.							29
4. Physiotherapists should be responsible for developing staff projections for the physiotherapy departments in their facilities.							30
5. Physiotherapists should have final authority over their work.							31
6. Physiotherapists as members of a health care team should be allowed to function more independently.							32
7. Physiotherapists within medical settings should be allowed to provide their services to clients in need of those services without the requirement of a physician's referral or prescription.							33
8. Physiotherapists should be allowed to make their own decisions regarding problems that come up with the treatment of their patients.							34
9. Many professions are provincially licensed with a licensure examination and, in some cases, the physiotherapist is licensed at the provincial level. To what extent do you agree that physiotherapists should be licensed by examination in Alberta?							35

SECTION C (cont'd)

	Strongly Disagree					Strongly Agree	cc
	1	2	3	4	5	6	
10. Membership in the provincial association should be a requirement to practise or hold a position.							36
11. Membership in the national association should be a requirement to practise or hold a position.							37
12. There should be a re-examination and re-licensing for any Physiotherapist who wishes to re-enter practice after an absence of five years or more.							38
13. To what extent do you agree that Physiotherapy as a profession has a firm core of theory and knowledge like medicine?							39
14. I sometimes do things that I should have been better prepared for in my course in Physiotherapy.							40
15. Continuing education in Physiotherapy should be developed to meet the future needs of the therapists.							41
16. Thinking of various jobs which Physiotherapists may hold five to ten years from now, Alberta would need a Master's program in Physiotherapy.							42
17. To what extent do you agree that university education in Physiotherapy is adequate?							43
18. To what extent do you agree that Physiotherapy education in a community college could be adequate to meet the training requirements of the profession?							44
19. It should be permissible for a Physiotherapist to violate medical protocol if it is in the best interests of the patient.							45
20. I feel the need for someone with a higher level of expertise in Physiotherapy in my facility.							46
21. The best interests of Physiotherapists would be served by conforming to professional standards rather than to standards of their employing institutions.							47

SECTION C (cont'd)

	Strongly Disagree 1	2	3	4	5	Strongly Agree 6	cc
22. Physiotherapists should be made more accountable for the treatment activities of their patients.							48
23. To what extent did you agree that Physiotherapy training prepared you to conduct and report research?							49
24. Physiotherapists should be evaluated only by their fellow Physiotherapists.							50
25. Because of what I am able to do for society, I would like to continue in my present profession even if I could earn more money at another vocation.							51
26. My Physiotherapy education prepared me adequately to carry out administrative/supervisory duties.							52
27. Physiotherapists should be involved in determining the program which will best meet patient care objectives.							53
28. Do you agree that Physiotherapy as a profession may be threatened by the growth and development of other occupations or professions?							54

For questions 29, 30 and 31, please respond in relation to this statement:

In many professions there are problems such as lack of power and influence, difficulty in relation to other professions, etc. Thinking of P.T.: -

	Strongly Disagree 1	2	3	4	5	Strongly Agree 6	cc
29. To what extent do you agree that the lack of a clearly defined area of competence in relation to other health professions account for some of the problems in Physiotherapy profession?							55
30. To what extent do you agree that the lack of training of Physiotherapists in dealing with government and other professions account for some of the problems in the profession?							56
31. To what extent do you agree that the fact that the majority of people in the profession are women account for some of the problems in the profession?							57

32. Listed below are ten occupations. Please rank them according to the way in which you think the public evaluates their social standing. Place the number "1" opposite the occupation to which you think the public attributes the highest social standing through to "10"--the occupation in the group to which you think the public attributes the lowest social standing.

				cc
___	Physicians	___	Hospital Secretary	58-59, 60-61
___	Dieticians	___	Prof. Social Workers	62-63, 64-65
___	School Teachers	___	Physiotherapists	66-67, 68-69
___	Laboratory Technologists	___	Registered Nurses	70-71, 72-73
___	Registered Occupational Therapists	___	Radiographers	74-75, 76-77

Comments (if any) ____

____

____

____

____

____

If you would like a report of the findings of this study, please contact your Association's headquarters later.

Thank you.

APPENDIX B

LETTER

from Dr. J. Balderson (thesis Advisor)
to the President of Alberta Association of
Registered Occupational Therapists

DEPARTMENT OF
EDUCATIONAL ADMINISTRATION
FACULTY OF EDUCATION
THE UNIVERSITY OF ALBERTA

February 12, 1980

Mrs. Gwen Cashion
3319 Upton Place N. W.
Calgary, Alberta
T2N 4G9

Dear Mrs Cashion,

This letter is to confirm that Mr. Philip Ogunleye, B. Sc. (O.T.) BMAOT, is engaged in a study designed to explore the attitudes of Occupational therapists and Physiotherapists in Alberta with respect to their profession and work.

Mr. Ogunleye would appreciate receiving the list of registered members of the Alberta Association of Registered Occupational Therapists. He will then forward survey froms to a sample of the members.

You may contact Mr. Ogunleye at the following address:

Dept. of Educational Administration
The University of Alberta
Edmonton, Alberta
T6G 2G5
Phone: 439-9518

Of course your association will be provided with a summary of the study's findings.

Thank you for your cooperation.

Yours sincerely,

James Balderson, Ph.D.
Associate Professor

JB/sl

APPENDIX C

FOLLOW UP LETTER

FACULTY OF EDUCATION
DEPARTMENT OF EDUCATIONAL
ADMINISTRATION

QUAECUMQUE VERA

THE UNIVERSITY OF ALBERTA
EDMONTON, CANADA
T6G 2G5

March 15, 1980

FOLLOW UP LETTER

Dear colleague,

A few weeks ago I mailed a questionnaire to you, attempting to explore the attitudes of occupational therapists and physiotherapists in Alberta with respect to their profession and work. While the response has been most gratifying, I believe I should await the return of a few more completed questionnaires before begining the analysis of the data.

Being fully aware of your rather tight schedule, I would request that you complete and return the questionnaire at your earliest convenience - preferably before the end of this month. My sample contains rather small number so that a high percentage of return is most important.

If your response is already in the mail, I extend my thanks, as well as my apologies for this reminder.

Compliments of the season.

Yours Sincerely,

Philip Ogunleye, B.Sc.(OT), BMAOT.